



U.S. Department of Homeland Security

Immigration and Customs Enforcement
Office of Professional Responsibility
Washington, DC 20536

External Reviews and Analysis Unit Detainee Death Review

Kamyar SAMIMI
Date of Death – December 2, 2017
Denver Contract Detention Facility
Aurora, Colorado

JICMS Case (b)(7)(E)

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MAY 22 2018



U.S. Immigration
and Customs
Enforcement

MEMORANDUM FOR: Matthew Albence
Executive Associate Director
Enforcement and Removal Operations

THROUGH: Waldemar Rodriguez *Waldemar Rodriguez*
Associate Director

FROM: Jennifer M. Fenton *Jennifer M. Fenton*
Assistant Director

SUBJECT: Findings – Death of ICE detainee Kamyar SAMIMI
(JICMS # (b)(7)(E))

The Office of Professional Responsibility, External Reviews and Analysis Unit (ERAU), has completed its investigation into the death of U.S. Immigration and Customs Enforcement (ICE) detainee Kamyar SAMIMI who died on December 2, 2018, while in ICE custody, at the University of Colorado Medical Center (UCMC) in Aurora, Colorado (CO). The Adams & Bakersfield County Coroner's Autopsy Report documented SAMIMI's cause of death as undetermined but listed chronic obstructive pulmonary disease (emphysema) and gastrointestinal bleeding as contributing factors.

On November 17, 2017, ERO arrested SAMIMI at his residence in Denver, CO and served him with a Notice To Appear (NTA) charging him as removable under section 237(a)(2)(b) of the Immigration and Naturalization Act (INA) as an alien convicted of a controlled substance violation. ERO transferred SAMIMI to the Denver Contract Detention Facility (DCDF)¹ in Aurora, CO, that same day.

During his intake screening on November 17, 2017, SAMIMI reported taking between 150-190mg of methadone daily and stated he was experiencing methadone withdrawal symptoms. Given SAMIMI's long-term use of high-dose methadone, nursing staff received orders from DCDF's physician to house the detainee in medical observation, complete laboratory work, take vital signs every eight hours, and give medications as needed for anxiety, restlessness, sleeplessness, nausea, and pain. The physician did not order monitoring of SAMIMI's withdrawal symptoms using any standardized instrument.²

¹ The facility is also referred to as the Aurora County Processing Center, but "DCDF" is used throughout this memorandum and the Detainee Death Review report for consistency.

² The Clinical Opiate Withdrawal Scale (COWS) is a widely-recognized and used instrument for monitoring opiate withdrawal. GEO also has a limited monitoring instrument entitled, "Alcohol/Drug Withdrawal Monitoring Sheet."

SAMIMI remained in the medical unit for the duration of his 16 days in detention, and his laboratory test results were within normal limits, with the exception of an abnormally high thyroid hormone and a slightly low hemoglobin level. In contravention of physician's orders, nurses took vital signs only twice daily, on average (rather than every eight hours). Although SAMIMI's observed condition indicated a need for withdrawal medications, nurses administered less than half of the doses ordered. DCDF's physician never physically examined the detainee.

Mental health professionals saw SAMIMI on three occasions. A staff psychologist conducted the initial evaluation in-person on November 20, 2017, and psychiatrists conducted the second and third evaluations via tele-psychiatry on November 29, and November 30, 2017, respectively. During the second evaluation, following his attempted suicide, the psychiatrist directed that SAMIMI's suicide watch level be lowered, prescribed medication changes, and ordered monitoring of his withdrawal symptoms using COWS. Medical staff never completed any COWS. During his final mental health encounter, two days before his death, SAMIMI stated he was stressed, depressed, and wanted to die due to his symptoms of methadone withdrawal. The psychiatrist continued SAMIMI on suicide watch and his medications.

All officers interviewed observed significant deterioration in SAMIMI's condition, especially during the 48 hours prior to his death, and expressed concern about the care provided by nursing staff during interviews. Nursing notes prepared during SAMIMI's detention, corroborated by video surveillance footage, reflect a progressive deterioration in SAMIMI's health, starting on November 22, 2017. They include the following observations regarding his condition: tremors, pain and weakness, nausea and vomiting, refusing meals, inability to sit up in bed or in a wheelchair, incontinence and signs of dehydration. The majority of nurses interviewed stated they believed SAMIMI was malingering and seeking drugs throughout his stay and did not see an urgent need to notify the physician of his worsening condition.

SAMIMI's condition started to rapidly deteriorate the night of December 1, 2017, when he appeared to spit up blood, complained of stomach pains throughout the night, and vomited frequently. The morning of December 2, 2017, while two officers and a nurse attempted to move SAMIMI into a wheelchair, he exhibited symptoms of seizure. The officers returned him to his mattress where they observed him vomit and urinate on himself. Over the following approximately six minutes, an RN made several unsuccessful attempts to contact the physician for guidance on managing SAMIMI. Meanwhile, the officers contacted their Lieutenant, who directed that 911 be called immediately. Emergency Medical Services (EMS) arrived on the scene approximately four minutes later. SAMIMI stopped breathing shortly after their arrival, and paramedics performed CPR during the detainee's transit to the Emergency Room (ER). ER staff were unable to resuscitate SAMIMI, and an ER physician pronounced his death at 12:02 p.m.

ERAU reviewed DCDF's compliance with the ICE PBNDS 2011 (revised 2016) as they relate to SAMIMI's medical care, safety and security, and found DCDF did not fully comply with the standards detailed below. These deficiencies are noted for informational purposes only, and should not be construed as contributory to the detainee's death.

1. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(B), states “All facilities shall provide medical staff and sufficient support personnel to meet these standards.” At the time of SAMIMI’s detention, DCDF had vacancies in key medical personnel, including a Director of Nursing and a midlevel provider, for longer than six months.
2. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(G)(12), states, “Each detention facility shall have and comply with written policy and procedures for the management of pharmaceuticals...to include: (12) documentation of accountability for administering or distributing medication in a timely manner, and according to licenses provider orders.” In spite of SAMIMI’s frequent and progressive complaints related to symptoms of withdrawal, nurses administered less than 50% of physician-ordered withdrawal medications to be given on an as needed basis.
3. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(J), states, “Where there is a clinically significant finding as a result of the initial screening, an immediate referral shall be initiated and the detainee shall receive a health assessment no later than two working days from the initial screening...” The intake nurse’s documentation of SAMIMI’s possible early opioid withdrawal did not result in an initial provider assessment within two working days of intake.
4. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(K), states, “Detainees experiencing severe or life-threatening intoxication or withdrawal shall be transferred immediately to an emergency department for evaluation. Once evaluated, the detainee will be referred to an appropriate facility qualified to provide treatment and monitoring for withdrawal, or treated on-site if the facility is staffed with qualified personnel and equipment to provide appropriate care.” DCDF medical staff failed to transfer SAMIMI to an ER even though he exhibited life threatening withdrawal symptoms in the week following his intake.
5. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(M), states, “Each facility’s health care provider shall conduct a comprehensive health assessment, including a physical examination and mental health screening, on each detainee within 14 days of the detainee’s arrival unless more immediate attention is required due to an acute or identifiable chronic condition.” DCDF failed to complete an initial physical assessment during the 15 days SAMIMI was housed at the facility, in part due to the absence of a midlevel provider.
6. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(N), states, “Where a detainee has a serious medical or mental health condition or otherwise requires special or close medical care, medical staff shall complete a Medical/Psychiatric Alert form (IHSC-834) or equivalent, and file the form in the detainee’s medical record.” Medical staff did not complete a Medical/Psychiatric alert for SAMIMI.
7. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(R), states, “An initial dental screening shall be performed within 14 days of the detainee’s arrival. The initial dental screening may be performed by a dentist or a properly trained qualified health

provider.” Medical staff did not schedule SAMIMI for a dental screening examination.

8. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(T), states, “An on-call physician, dentist, and mental health professional or designee, are available 24 hours per day.” Nurses reported difficulty reaching Dr. (b)(6);(b)(7) outside of his work hours. On the day of SAMIMI’s death, the physician did not answer or return two phone calls.
9. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(U), which states, “Distribution of medication (including over the counter) shall be performed in accordance with specific instructions and procedures established by the HSA, in consultation with the CMA. Written records of all prescribed medication given to or refused by detainees shall be maintained.” Nurses failed to document administration of SAMIMI’s medications on numerous occasions.
10. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(X), which states, “The facility administration and clinical medical authority shall ensure that the Field Office Director is notified as soon as practicable of any detainee housed at the facility who is determined to have a serious physical or mental illness or to be pregnant, or have medical complications related to advanced age, but no later than 72 hours after such determination. The written notification shall become part of the detainee’s health record file.” DCDF did not notify the Field Office Director that SAMIMI was withdrawing from methadone and that his condition deteriorated during the detention period.
11. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(AA), which states, “Prior to the administration of psychotropic medication, a separate documented informed consent, that includes a description of the medication’s side effects.” An informed consent specific to the anti-depressant/sedative Trazodone was not completed and signed by the detainee.
12. ICE PBNDS 2011 (revised 2016), *Significant Self Harm and Suicide Prevention and Intervention*, Section (V)(F), which states, “All suicidal detainees placed in an isolated confinement setting will receive continuous one-to-one monitoring, welfare checks at least every 8 hours conducted by clinical staff, and daily mental health treatment by a qualified clinician.” Nursing staff did not conduct a welfare check on SAMIMI during the 14 hours between his placement on suicide watch and his evaluation via tele-psychiatry.

In addition to these findings of non-compliance, ERAU identified several areas of concern which are discussed in the attached report.

If you have any questions, please contact me or have a member of your staff contact Unit Chief, (b)(6);(b)(7)(C) at (202)732-(b)(6);(b)(7)(C)

Attachment

cc: Peter T. Edge

(b)(6);(b)(7)(C)

SYNOPSIS

On December 2, 2017, Kamyar SAMIMI, a sixty-four year old citizen of Iran, died while in the custody of U.S. Immigration and Customs Enforcement (ICE) at the University of Colorado Medical Center (UCMC), in Aurora, Colorado (CO). The Adams & Broomfield County Coroner's Autopsy Report for Kamyar SAMIMI listed the cause of death as undetermined. The report listed chronic obstructive pulmonary disease (emphysema) and gastrointestinal bleeding as contributing factors.

SAMIMI was detained at Denver Contract Detention Facility (DCDF),¹ in Aurora, CO, from November 17, 2017, until his death. DCDF is privately-owned and operated by the GEO Group, Inc. (GEO) and is required to comply with the ICE Performance Based National Detention Standards (PBNDS) 2011. Medical care at DCDF is provided by Correctional Care Solutions (CCS). At the time of SAMIMI's death, DCDF housed approximately 736 ICE detainees of all classification levels for periods in excess of 72 hours.

DETAILS OF REVIEW

From January 9 to 11, 2017, ICE Office of Professional Responsibility, External Reviews and Analysis Unit (ERAU) staff visited DCDF to review the circumstances surrounding SAMIMI's death. ERAU was assisted in its review by contract subject matter experts (SME) in correctional healthcare and security.² ERAU's contract SMEs are employed by Creative Corrections, a national management and consulting firm. As part of its review, ERAU examined immigration, medical, and detention records pertaining to SAMIMI, in addition to conducting in-person interviews of individuals employed by GEO, CCS, and the local field office of ICE's Office of Enforcement and Removal Operations (ERO).

During the review, the ERAU team took note of any deficiencies observed in the detention standards as they relate to the care and custody of the deceased detainee and documented those deficiencies herein for informational purposes only. Their inclusion in this report should not be construed in any way as indicating the deficiencies identified contributed to the detainee's death. ERAU determined the following timeline of events, from the time of SAMIMI's apprehension by ICE, through his detention at DCDF, and eventual death at UCMC³.

IMMIGRATION AND CRIMINAL HISTORY⁴

In 1976, the legacy Immigration and Naturalization Service (INS) admitted SAMIMI to the United States (U.S.) through New York, NY, under an F-1 non-immigrant student visa. In 1979, SAMIMI adjusted his status to Lawful Permanent Resident (LPR) based on his marriage to a

¹ The facility is also referred to as the Aurora County Processing Center, but "DCDF" is used throughout this report and the accompanying memorandum for consistency.

² See Exhibit 1: Creative Corrections Medical and Security Compliance Analysis.

³ Throughout the narrative, several event descriptions are supplemented by a description of the corresponding Closed Captioned Television (CCTV) footage. Additionally, although referenced specifically on certain dates, the entirety of the detainee's vital signs and medication administrations are captured in tables found in Appendix 1, and Appendix 2, respectively.

⁴ See Detainee Death Notice.

U.S. citizen. SAMMI applied for naturalization in 1985, and the INS denied his application in 1987 for failure to submit the proper documentation.

On June 9, 2005, SAMIMI plead guilty to Possession of a Controlled Substance (Schedule 2) and Possession of Drug Paraphernalia. He received a deferred sentence (2 years) and 64 days of public service.

On November 17, 2017, ERO arrested SAMIMI at his residence in Denver, CO and served him with a Notice To Appear (NTA) charging him as removable under § 237(a)(2)(b) of the Immigration and Naturalization Act (INA) as an alien convicted of a controlled substance violation. ERO transferred SAMIMI to the DCDF that same day.

NARRATIVE

On November 17, 2017, at 4:00 p.m., SAMIMI arrived at DCDF. Security staff appropriately classified him as medium-low based on his criminal history and assigned him to a general population housing unit.⁵ At approximately at 9:30 p.m., prior to being housed, SAMIMI received a medical intake screening by Licensed Practical Nurse (LPN) (b)(6);(b)(7)(C). LPN (b)(6);(b)(7)(C) noted that SAMIMI spoke English. SAMIMI's vital signs were all within normal limits⁶ with the exception of an abnormally-elevated blood pressure of 146/94. His height was five feet, seven inches tall, and his weight was 135 pounds. LPN (b)(6);(b)(7)(C) documented that SAMIMI reported taking 190 milligrams (mg) of methadone daily and that he was suffering withdrawal symptoms,⁷ though she did not specify how long he had taken methadone or the date of his last use.⁸ The intake screening form prompts the user to document evident symptoms of withdrawal; LPN (b)(6);(b)(7)(C) did not include any for SAMIMI because, according to her, SAMIMI was stable and steady on his feet and did not appear to have tremors or other withdrawal symptoms.⁹

LPN (b)(6);(b)(7)(C) recalled that the only symptom SAMIMI reported was anxiety and that he repeatedly stated he needed methadone for chronic back pain caused by a car accident.¹⁰ SAMIMI reported sharp back pain at a level five on a scale of zero to ten¹¹ during screening. SAMIMI's reported substance abuse history included consumption of two to three beers occasionally over the past thirty years, cocaine/crack one time weekly over the past twenty years, marijuana once weekly and opium daily twenty years prior. He also reported smoking ten cigarettes a day, his last having been ten hours earlier.¹²

⁵ See ICE Custody Classification Worksheet, dated November 17, 2017.

⁶ Normal temperature is 98.6; normal range for pulse is 60 to 100 beats per minute; normal range for respirations is 12 to 20 breaths per minute; and, normal blood pressure is 120/80, with 90/60 to 139/89 considered within normal range. See Exhibit 1.

⁷ See Exhibit 2: GEO Medical Intake Screening by LPN (b)(6);(b)(7)(C) dated November 17, 2017.

⁸ ERAU Interview with LPN (b)(6);(b)(7)(C) dated December 09, 2017.

⁹ Early signs of opiate withdrawal include running nose, sweating, tearing, yawning, dilated pupils, and increased temperature. Later signs include loss of appetite, nausea, vomiting, diarrhea, goose flesh, increased blood pressure, increased pulse, restlessness, and severe muscle and joint pain. See Exhibit 1.

¹⁰ ERAU Interview with LPN (b)(6);(b)(7)(C) dated December 09, 2017.

¹¹ The zero to ten scale is a standardized method of determining patient pain presence and severity, allowing practitioners to determine the need for and the effectiveness of pain treatment. Zero indicates no pain, while a level ten indicates the worst pain one has ever experienced. See Exhibit 1.

¹² See Exhibit 2: GEO Medical Intake Screening by LPN (b)(6);(b)(7)(C) dated November 17, 2017.

LPN (b)(6);(b)(7)(C) added SAMIMI to the “blood pressure list”, which required medical staff to conduct blood pressure checks three times weekly for two weeks and referral to a provider for elevated blood pressure.¹³ SAMIMI’s placement on the blood pressure list effectively identified him as a chronic care patient.¹⁴

LPN (b)(6);(b)(7)(C) initially cleared SAMIMI for general population;¹⁵ however, RN (b)(6);(b)(7)(C) directed security staff to bring him to the clinic before housing him after LPN (b)(6);(b)(7)(C) notified her of his reported withdrawal. When RN (b)(6);(b)(7)(C) spoke with SAMIMI, he stated that he took 190 mg of methadone on a daily basis for detoxification from other drugs.¹⁶ SAMIMI signed a consent for medical, dental, and mental health services¹⁷ and an authorization for DCDF to obtain his health information.¹⁸ A screening chest x-ray completed during SAMIMI’s intake screening showed no acute cardiopulmonary disease or evidence of active tuberculosis.¹⁹

After evaluating SAMIMI, RN (b)(6);(b)(7)(C) called Dr. (b)(6);(b)(7)(C) to report the detainee’s methadone use and documented receipt of the following telephone orders from Dr. (b)(6);(b)(7)(C):

1. Stat²¹ laboratory studies to include a complete blood count,²² comprehensive metabolic panel,²³ thyroid stimulating hormone,²⁴ and formal urine.²⁵ RN (b)(6);(b)(7)(C) drew the blood samples and sent them for laboratory testing.²⁶
2. Medications for withdrawal, to include:²⁷

¹³ *Id.*

¹⁴ ERAU Interview with HSA (b)(6);(b)(7)(C) dated December 09, 2017.

¹⁵ ERAU Interview with LPN (b)(6);(b)(7)(C) dated December 09, 2017.

¹⁶ ERAU Interview with RN (b)(6);(b)(7)(C) dated December 09, 2017.

¹⁷ See GEO Consent to Medical, Dental, Mental Health Services and Medical Interpretation, dated November 17, 2017.

¹⁸ See GEO Authorization to Disclose/Obtain Protected Health Information, dated November 17, 2017.

¹⁹ See Pacific Mobile Radiology Report, dated November 18, 2017.

²⁰ RN (b)(6);(b)(7)(C) did not document whether the orders were read back to verify accuracy, and Dr. (b)(6);(b)(7)(C) did not sign to authenticate his verbal orders. The Colorado Revised Statutes Title 25 Health § 25-3-111 requires verbal order authentication within 48 hours, unless a read-back and verify process is in place, in which case the authentication must occur within 30 days.

²¹ Stat means immediate. See [Exhibit 1](#).

²² A complete blood count is a test that provides information about the various cell concentration in a patient’s blood to assist in disease diagnosis. See [Exhibit 1](#).

²³ A comprehensive metabolic panel is a test that provides information about the status of your metabolism, including kidney and liver function, electrolyte balance, blood glucose, and blood proteins, in order to monitor such conditions as hypertension and diabetes. See [Exhibit 1](#).

²⁴ A thyroid stimulating hormone (TSH) test is a blood test that measures the level of this hormone to determine if the thyroid gland is functioning properly. See [Exhibit 1](#).

²⁵ A formal urine, or urinalysis, is a test that analyzes the culture and contents of a urine sample. See [Exhibit 1](#).

²⁶ ERAU Interview with RN (b)(6);(b)(7)(C) dated December 09, 2017. According to RN (b)(6);(b)(7)(C) she drew blood samples and sent them to the laboratory that same night; however, the laboratory report documents their receipt date as November 20, 2017.

²⁷ Dr. (b)(6);(b)(7)(C) ordered all withdrawal medications on an as needed basis. Per Creative Corrections, standard nursing practice calls for assessment of patient symptoms prior to administration of as needed medications, and documentation of the justification for administration in a nursing note and recordation of the administration in both a

- Ativan²⁸ 1 mg intramuscularly up to three times daily as needed for 15 days.²⁹
- Clonidine³⁰ 0.1 mg orally up to three times daily as needed for 15 days.

Note: As noted by Creative Corrections, GEO Clinical Practice Guidelines (CPG) for opiate withdrawal calls for giving clonidine in doses of 0.1 to 0.2 mg orally three to four times daily, as a means of controlling hypertension and somnolence,³¹ and suggests interval dosing at specific times rather than on an as needed basis. Although Dr. (b)(6);(b)(7) ordered administration as needed, the Medication Administration Records (MAR) for both clonidine and Ativan set 9:00 a.m., 3:00 p.m., and 9:00 p.m., as the times for administration. The MAR entries for all of SAMIMI's ordered medications were inconsistent throughout the detention period, with times not recorded at all or noted at times which did not align with nursing notes. Regarding the irregular MAR entries, RN (b)(6);(b)(7)(C) stated that at least for clonidine, nurses selected whichever of the three set times was closest to when they gave SAMIMI a dose. Per Creative Corrections, by failing to document the actual time they gave clonidine, Ativan, and other medications, the nurses risked administering those medications either in a premature or delayed manner.

Additionally, the CPG states blood pressure and heart rate levels must be obtained prior to each dose of clonidine, and that the medication should be withheld if systolic blood pressure³² falls below 90. Dr. (b)(6);(b)(7)(C) order did not include this guidance. Because nurses documented taking SAMIMI's vital signs less than half the time ordered, and because they did not consistently and accurately document the times they administered clonidine and other medications, SAMIMI's record does not demonstrate whether his blood pressure was taken before he received clonidine. As noted by Creative Corrections, and detailed in Appendix 1, SAMIMI's blood pressure was in the normal range when taken, which suggests the clonidine effectively controlled any hypertension caused by his withdrawal.

- Cyclobenzaprine³³ 10 mg orally up to three times daily as needed for 15 days.
- Ibuprofen³⁴ 800 mg orally up to three times daily as needed for 15 days.
- Phenergan³⁵ 25 mg orally up to three times daily as needed for 15 days.

nursing note and on the MAR. SAMIMI's medical record reflects that nurses did not consistently document assessment of his symptoms to determine the need for medications, nor did they consistently document administration in either a nursing note or on the MAR.

²⁸ Ativan is a medication to treat anxiety. See Exhibit 1.

²⁹ RN (b)(6);(b)(7)(C) note documents 1mg of Ativan was administered intramuscularly in the right deltoid on this date; additionally, the administration of the medication was not recorded on the MAR.

³⁰ Clonidine is a medication with sedating properties, used to treat high blood pressure. See Exhibit 1.

³¹ Somnolence is a state of feeling drowsy, increasing risk of injury. See Exhibit 1.

³² Systolic blood pressure is reflected in the top number. See Exhibit 1.

³³ Cyclobenzaprine is a muscle relaxant medication. See Exhibit 1.

³⁴ Ibuprofen is a medication to treat pain. See Exhibit 1.

3. Hold (house) in medical.
4. Appointments with psychology and physician.
 - SAMIMI was seen by the psychologist on November 20, 2017,³⁶ described below, but nursing staff never added him to Dr. (b)(6);(b)(7)(C) Provider Appointment Log, despite the doctor's order and the clinically-significant findings identified during the intake screening.³⁷
5. Increase and encourage fluids.
6. Vital signs every eight hours until further notice.³⁸
 - Although RN (b)(6);(b)(7)(C) created a MAR for SAMIMI's vital signs which specified they be taken every eight hours, nurses did not make any notations on the vital signs MAR throughout his detention. Nurses only documented vital signs in their notes, and on three occasions (November 25, November 30, and December 1, 2017) documented blood pressure readings on a separate Blood Pressure Record. Further, nursing notes show SAMIMI's vital signs were taken only once or twice per day rather than every eight hours. Health Services Administrator (HSA) (b)(6);(b)(7)(C) stated nurses mistakenly understood that vital signs were to be conducted once per shift, and because many worked 12 hour shifts, vital signs were not taken every eight hours as ordered.³⁹ Additionally, SAMIMI was not weighed again following intake, and his pulse oxygen saturation was not consistently taken with vital signs. Dr. (b)(6);(b)(7) stated pulse oxygen saturation and body weight should typically be taken when obtaining vital signs.⁴⁰

Dr. (b)(6);(b)(7) stated that his orders were based on GEO's CPG for opioid withdrawal.⁴¹ Dr. (b)(6);(b)(7) stated he opted not to order an EKG as recommended in the CPG because he thought it more important to have the laboratory tests done. Dr. (b)(6);(b)(7) indicated that opioid withdrawal assessment instruments provide guidance, but they "are not really protocol." He added that detainees typically finish withdrawing in three to four days, but because SAMIMI reported use of high dose methadone over several years, his withdrawal was prolonged. Creative Corrections notes that while the CPG does not address use of an assessment instrument, the National

³⁵ Phenergan is a medication with sedating and pain control properties, used to treat nausea. See Exhibit 1.

³⁶ See GEO Mental Health Evaluation, dated November 20, 2017.

³⁷ SAMIMI was not physically examined by the physician during the detention period.

³⁸ See Appendix 1: SAMIMI Vital Signs, for all vital signs recorded by medical staff through the detention period.

³⁹ ERAU Interview with HSA (b)(6);(b)(7) dated December 09, 2017.

⁴⁰ ERAU Interview with Dr. (b)(6);(b)(7) dated December 10, 2017.

⁴¹ Dr. (b)(6);(b)(7) and HSA (b)(6);(b)(7) both noted the GEO CPG mirrors that of the Federal Bureau of Prisons.

Commission on Correctional Health Care (NCCHC)⁴² mandates monitoring using validated instruments.⁴³

At approximately 10:30 p.m., RN (b)(6);(b)(7)(C) conducted a nursing round during which SAMIMI stated he felt terrible. SAMIMI's vital signs were within normal limits with the exception of a slightly elevated blood pressure of 130/94. He denied chest and abdominal pain but complained of generalized level eight pain.⁴⁴ RN (b)(6);(b)(7)(C) noted SAMIMI reported nausea and vomiting two hours earlier and described his emesis⁴⁵ as "hardly anything" and "greenish" in color. He reported he had a "watery" bowel movement on November 20, 2017.⁴⁶ RN (b)(6);(b)(7)(C) noted tremors in his hands and an unsteady gait. Her nursing plan included continued monitoring and encouraging fluid intake.⁴⁷

Security staff assigned SAMIMI to medical observation cell 537 per Dr. (b)(6);(b)(7)(C) order,⁴⁸ and at 11:14 p.m. SAMIMI entered the cell unassisted and made his bed without difficulty.⁴⁹ Officer (b)(6);(b)(7)(C) was the assigned medical officer when SAMIMI arrived. Officer (b)(6);(b)(7)(C) described SAMIMI as very talkative and very thin. She recalled a nurse obtained a blood sample, but SAMIMI was unable to provide a urine sample. SAMIMI asked for Gatorade, which Officer (b)(6);(b)(7)(C) obtained from nurses in powdered version and provided to SAMIMI.⁵⁰

On November 18, 2017, SAMIMI accepted all three meal trays but declined both recreation and a shower.⁵¹ Officer (b)(6);(b)(7)(C) stated that when she collected the detainee's breakfast tray, she noted all items were consumed, but when she returned to duty for the evening shift, some of the dinner meal remained on the tray.⁵²

⁴² DCDF was NCCHC-accredited at the time of SAMIMI's detention; the facility is due for re-accreditation in 2018.

⁴³ The Clinical Opiate Withdrawal Scale (COWS)⁴³ is the most widely-recognized and used instrument. Although GEO has a limited instrument titled, "Alcohol/Drug Withdrawal Monitoring Sheet," neither a COWS nor the GEO instrument were completed during SAMIMI's detention.

⁴⁴ RN (b)(6);(b)(7)(C) did not document the location or nature of the pain.

⁴⁵ Emesis is vomit, via the forceful expulsion of the contents of one's stomach through the mouth and sometimes the nose. See Exhibit 1.

⁴⁶ November 20, 2017, was three days after the date of this encounter. RN (b)(6);(b)(7)(C) admitted the date recorded was an error and could not recall the date SAMIMI reported.

⁴⁷ See GEO Medical Observation Nursing Progress Record by RN (b)(6);(b)(7)(C) dated November 17, 2017.

⁴⁸ Cell 537 is accessed via an enclosed anteroom which includes a sink. The door to the cell has a window in the top half, and to the left of the door is another large viewing window. The cell has a single bed on the left, a toilet behind a half wall and a shower behind a full wall. A camera is in the upper left corner of the cell. A monitor on the officer's desk displays live video feed of the interior of all cells in the clinic.

⁴⁹ See GEO CCTV footage, dated November 17, 2017.

⁵⁰ ERAU Interview with Officer (b)(6);(b)(7)(C), dated December 10, 2017.

⁵¹ SAMIMI's Medical Unit Housing Record Log does not document that he ever accepted the opportunity to shower. While officers would not necessarily have noticed and recorded his use of the shower within cell 537, showering after placement on suicide watch would have necessitated release from the cell to do so and entry in the log by the officer. No officer interviewed recalled SAMIMI ever showering.

⁵² ERAU Interview with Officer (b)(6);(b)(7)(C), dated December 10, 2017.

RN (b)(6);(b)(7)(C) completed a GEO Alcohol Withdrawal Assessment and Treatment Flow Sheet (*Clinical Institute Withdrawal Assessment (CIWA)*)⁵³ at 1:45 p.m.⁵⁴ SAMIMI was given a CIWA score of seven, indicating the level of alcohol withdrawal did not require medication treatment. Creative Corrections notes that the CIWA is specific to *alcohol* withdrawal, and although many of the same symptoms are experienced by persons withdrawing from opioids, there are clinical differences which are factored in scores on the respective assessment forms. RN (b)(6);(b)(7)(C) stated that she knows that alcohol and opioid withdrawal are clinically different and that she inadvertently used the wrong form.⁵⁵

SAMIMI consumed an unspecified amount of water at 4:40 p.m. and ate 40 percent of his dinner at 4:50 p.m. SAMIMI reported his last bowel movement was the previous day. His skin was warm and flushed, and he complained of headache pain at a level six.⁵⁶

At 6:00 p.m. RN (b)(6);(b)(7)(C) documented that SAMIMI was experiencing nausea. His vital signs were within normal limits. He denied all pain but appeared pale. With the exception of nausea, RN (b)(6);(b)(7)(C) did not document any signs or symptoms of withdrawal. SAMIMI reported his last bowel movement was earlier in the day, and that he ate approximately 70 percent of his evening meal.⁵⁷

At approximately 10:00 p.m., SAMIMI spoke with LPV (b)(6);(b)(7)(C) and indicated he had pain in his back, that the back pain was due to a previous car accident, and that he took methadone for pain. SAMIMI was alert and oriented with no shortness of breath or distress observed. He complained of methadone withdrawal symptoms, including a stomachache and shivering. LPN (b)(6);(b)(7)(C) stated she informed RN (b)(6);(b)(7)(C) of SAMIMI's symptoms and believed RN (b)(6);(b)(7)(C) consulted Dr. (b)(6);(b)(7)(C). However, SAMIMI's medical record contains no documentation RN (b)(6);(b)(7)(C) contacted Dr. (b)(6);(b)(7)(C).

On November 19, 2017, SAMIMI accepted all three meals and declined recreation and a shower. The medical officer noted at 10:40 a.m., that SAMIMI said he was in a lot of pain. The officer informed Nurse (b)(6);(b)(7)(C) at 10:42 a.m., and at 10:47 a.m. Nurse (b)(6);(b)(7)(C) gave SAMIMI ibuprofen.⁵⁸ Nurses did not create documentation of any nursing rounds or progress notes in the medical record this date. HSA (b)(6);(b)(7)(C) acknowledged during interview that nurses should have documented all encounters with SAMIMI.⁵⁹

⁵³ CIWA is a tool used to assign points specifically to symptoms of alcohol withdrawal, with total scores indicating the severity of withdrawal. Per the CIWA, a score of 15 or higher indicates severe alcohol withdrawal. See Exhibit 1.

⁵⁴ See GEO Alcohol Withdrawal Assessment and Treatment Flowsheet, dated November 18-26, 2017.

⁵⁵ ERAU Interview with RN (b)(6);(b)(7)(C) dated December 09, 2017.

⁵⁶ See GEO Medical Observation Nursing Progress Record by RN (b)(6);(b)(7)(C) dated November 18, 2017.

⁵⁷ ERAU Interview with RN (b)(6);(b)(7)(C) dated December 11, 2017.

⁵⁸ See GEO Medical Progress Note by LPN (b)(6);(b)(7)(C) dated November 18, 2017. ERAU notes LPN (b)(6);(b)(7)(C) erroneously referred to RN (b)(6);(b)(7)(C) as RN (b)(6);(b)(7)(C) in her note on this date.

⁵⁹ See GEO Medical Housing Unit Log, dated November 19, 2017.

⁶⁰ ERAU Interview with HSA (b)(6);(b)(7)(C) dated December 09, 2017.

On November 20, 2017, SAMIMI accepted all three meals.⁶¹ RN (b)(6);(b)(7)(C) completed a CIWA form, with a score of 13, at 9:30 a.m., but did not initial or sign it.⁶² RN (b)(6);(b)(7)(C) recorded SAMIMI's vital signs were within normal limits except for a slightly elevated blood pressure. She applied points on the CIWA for symptoms of nausea/vomiting, tremors, and paroxysmal⁶³ sweating, and anxiety.⁶⁴ As noted by Creative Corrections, although the CIWA was not the proper assessment instrument, the categories in which RN (b)(6);(b)(7)(C) applied points are symptoms of opioid withdrawal.

Dr. (b)(6);(b)(7)(C) Psychologist, conducted a mental health evaluation for SAMIMI at 1:15 p.m. SAMIMI denied a history of suicidal or homicidal intent, self-harm, alcohol use, domestic violence, sexual assault, or violence toward self or others. SAMIMI reported he first used opium in Iran when he was four years old, and explained that his grandfather, a doctor, administered the narcotic to him for an earache. He said he made a decision to use opium recreationally at the age of 14 while still in Iran. SAMIMI reported he migrated to methadone in 1991, at the recommendation of a mental health professional, and has taken methadone daily since that time. SAMIMI responded to questions logically and cooperatively, was fully oriented, exhibited no signs of psychosis, and denied delusions or hallucinations as part of withdrawal.⁶⁵

At 7:00 p.m., SAMIMI spoke with RN (b)(6);(b)(7)(C) SAMIMI denied pain or nausea, although RN (b)(6);(b)(7)(C) observed he had tremors and appeared anxious. RN (b)(6);(b)(7)(C) did not record vital signs during this encounter but gave SAMIMI an injection of Ativan, which she administered in the right deltoid muscle. She did not record the dose of Ativan on the MAR.⁶⁶

On November 21, 2017, SAMIMI accepted all three meals but declined recreation and a shower.⁶⁷ Dr. (b)(6);(b)(7)(C) received and signed the results of SAMIMI's laboratory tests ordered on November 17, 2017. All tests were within normal limits with the exception of a slightly low hemoglobin level and an elevated thyroid hormone level. During interview, Dr. (b)(6);(b)(7)(C) called the lab results "excellent" overall and cited them as a reason he was not concerned about the ability of DCDF to manage SAMIMI's withdrawal.⁶⁸ At 6:30 p.m., SAMIMI spoke with RN (b)(6);(b)(7)(C) and denied pain but appeared anxious and was experiencing tremors. His vital signs were within normal limits. RN (b)(6);(b)(7)(C) gave SAMIMI Ativan, which she administered in his right deltoid muscle, which she did not document on SAMIMI's MAR.⁶⁹ She also encouraged the detainee to consume fluids. Her nursing plan included continued monitoring.

⁶¹ See GEO Medical Housing Unit Log, dated November 20, 2017.

⁶² ERAU Interview with RN (b)(6);(b)(7)(C) dated December 09, 2017. RN (b)(6);(b)(7)(C) stated she is untrained in opiate withdrawal monitoring and is therefore unfamiliar with an appropriate assessment instrument such as the COWS or GEO Form.

⁶³ A paroxysmal symptom is a sudden recurrence or intensification of symptom. See Exhibit 1.

⁶⁴ See GEO Alcohol Withdrawal Assessment and Treatment Flowsheet, dated November 18-26, 2017.

⁶⁵ See GEO Mental Health Evaluation by Dr. (b)(6);(b)(7)(C) dated November 20, 2017.

⁶⁶ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated November 20, 2017.

⁶⁷ See GEO Medical Housing Unit Log, dated November 21, 2017.

⁶⁸ ERAU Interview with Dr. (b)(6);(b)(7)(C) dated December 10, 2017.

⁶⁹ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated November 21, 2017.

On November 22, 2017, SAMIMI accepted all three meals but declined recreation and a shower.⁷⁰ At 6:00 p.m., SAMIMI spoke with RN (b)(6);(b)(7)(C) who documented SAMIMI complained of nausea and vomiting, generalized pain, tremors, and shivering related to methadone withdrawal. SAMIMI's vital signs were all within normal limits. SAMIMI reported his last caloric intake was at 5:00 p.m. at which time he ate 50 percent of his dinner, and he complained of nausea after eating. RN (b)(6);(b)(7)(C) nursing plan included continued monitoring, administration of medications, and increasing fluids as tolerated.⁷¹

On November 23, 2017, SAMIMI accepted all three meals but declined recreation and a shower.⁷² At 11:15 a.m., RN (b)(6);(b)(7)(C) observed that SAMIMI was alert and oriented, with mild hand tremors and level four generalized pain. SAMIMI's vital signs were all within normal limits. RN (b)(6);(b)(7)(C) encouraged SAMIMI to increase his fluid intake.⁷³

At 1:30 p.m., RN (b)(6);(b)(7)(C) spoke with SAMIMI, who complained of pain and weakness and spent most of the shift in bed. His vital signs were all within normal limits with the exception of a mildly elevated blood pressure of 134/93.⁷⁴

On November 24, 2017, SAMIMI did not accept any of his three meals and declined recreation and a shower. The medical officer noted that SAMIMI did not eat breakfast due to abdominal pain and that he notified a nurse.⁷⁵

During the early morning hours (4:11 a.m. to 7:45 a.m.), the medical officer logged that SAMIMI had difficulty sleeping, asked for ice chips, and cried out for a nurse several times due to abdominal pain. The officer logged notifying a nurse of SAMIMI's complaints and receiving permission to give the detainee ice chips. The officer logged that a nurse did not assess SAMIMI until 11:15 a.m., at which time the nurse administered medications and approved more ice chips. The medical record contains no entries addressing these events.

At 1:45 p.m., Officer (b)(6);(b)(7)(C) conducted a security round. SAMIMI approached his cell door and told her he was having abdominal pain. She told him she would notify nursing staff, but before she left to get a nurse, SAMIMI fell to the floor of his cell. Officer (b)(6);(b)(7)(C) called for nursing assistance,⁷⁶ and RN (b)(6);(b)(7)(C) Captain (b)(6);(b)(7)(C) and other responders arrived.⁷⁷

RN (b)(6);(b)(7)(C) stated that when he arrived, SAMIMI was unresponsive and lying on his back on the floor. RN (b)(6);(b)(7)(C) applied a sternal rub, and SAMIMI began to regain consciousness. RN (b)(6);(b)(7)(C) stated he assisted SAMIMI into a seated position, at which time the detainee made eye contact and stated he had not eaten in four days. He then lost consciousness a second time. RN (b)(6);(b)(7)(C) who also responded, performed a second sternal rub, SAMIMI regained consciousness, and the nurses assisted him into a seated position on his bed. SAMIMI complained of nausea, vomiting,

⁷⁰ See GEO Medical Housing Unit Log, dated November 22, 2017.

⁷¹ See GEO Medical Observation Nursing Progress Record by RN (b)(6);(b)(7)(C) dated November 22, 2017.

⁷² See GEO Medical Housing Unit Log, dated November 23, 2017.

⁷³ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated November 23, 2017.

⁷⁴ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated November 23, 2017.

⁷⁵ See GEO Medical Housing Unit Log, dated November 24, 2017.

⁷⁶ See GEO General Incident Report by Officer (b)(6);(b)(7)(C) dated November 24, 2017.

⁷⁷ See GEO Medical Housing Unit Log, dated November 24, 2017.

and being unable to eat. He requested to lie down, and the nurses assisted him to the supine⁷⁸ position. RN (b)(6);(b)(7)(C) conducted a nursing assessment and found SAMIMI's pupils were equal, round, and reactive to light. RN (b)(6);(b)(7)(C) did not assess SAMIMI for possible injuries resulting from his fall. SAMIMI's vital signs were within normal limits with the exception of an abnormally elevated pulse rate of 102, and an abnormally low oxygen saturation of 93 percent. RN (b)(6);(b)(7)(C) documented the detainee was dehydrated, possibly drug-seeking, and noted the nursing plan was to administer Ativan and Phenergan. RN (b)(6);(b)(7)(C) provided education on diet, medications, and the importance of good nutrition and fluid intake, and SAMIMI acknowledged understanding.⁷⁹ RN (b)(6);(b)(7)(C) did not document whether he contacted Dr. (b)(6);(b)(7)(C) regarding SAMIMI's dehydration and withdrawal symptoms but stated during interview that Dr. (b)(6);(b)(7)(C) is difficult to reach when not at the facility, and he may not have attempted to contact him on this date.

DCDF CCTV footage documented the following sequence of events following SAMIMI's fall: ⁸⁰

- At 1:50:39 p.m., SAMIMI lay on his back on the floor, and Officer (b)(6);(b)(7)(C) left to get assistance.
- At 1:50:52 p.m., Officer (b)(6);(b)(7)(C) returned to the cell and opened the cell door.
- At 1:51:51 p.m., RN (b)(6);(b)(7)(C) entered the cell, stepped over the detainee, donned gloves, kneeled at the detainee's side to check his pulse, and then performed a sternal rub.
- At 1:52:27 p.m., RN (b)(6);(b)(7)(C) pulled SAMIMI to a sitting position. As seen in the footage SAMIMI's head visibly lolls, and the detainee does not appear to be conscious.
- At 1:53:38 p.m., RN (b)(6);(b)(7)(C) entered the cell, and RN (b)(6);(b)(7)(C) repositioned SAMIMI so his back faced the wall away from his bunk, and RN (b)(6);(b)(7)(C) appeared to check SAMIMI's head.
- At 1:54:54 p.m., RN (b)(6);(b)(7)(C) and RN (b)(6);(b)(7)(C) lifted SAMIMI and moved him to the bed. SAMIMI appeared limp but was able to sit with support. RN (b)(6);(b)(7)(C) wheeled in the mobile electronic vital signs monitor and applied the cuff to the SAMIMI's left arm. After removing the cuff, RN (b)(6);(b)(7)(C) left with the blood pressure machine.
- At 1:58:04 p.m., RN (b)(6);(b)(7)(C) returned with a pulse oximeter which he placed on the detainee's finger.
- At 1:58:43 p.m., SAMIMI motioned to RN (b)(6);(b)(7)(C) to bring him the wastebasket from the corner of the room. RN (b)(6);(b)(7)(C) placed the wastebasket in front of him and SAMIMI vomited into it. He then placed both arms on the basket for support and placed his head directly over the basket. After a minute, RN (b)(6);(b)(7)(C) pulled SAMIMI away from the wastebasket, and the detainee sat up on the bunk unassisted. After another minute, RN (b)(6);(b)(7)(C) left SAMIMI alone in the cell.

At 3:12 p.m., Officer (b)(6);(b)(7)(C) logged that SAMIMI appeared to be doing much better.

At 8:30 p.m., RN (b)(6);(b)(7)(C) spoke with SAMIMI, and the detainee complained of nausea and vomiting. SAMIMI's vital signs were all within normal limits, with the exception of a slightly

⁷⁸ The supine position means lying face up. See Exhibit 1.

⁷⁹ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C), dated November 24, 2017.

⁸⁰ See GEO CCTV footage, dated November 24, 2017.

elevated temperature of 98.8 signifying a slight fever. SAMIMI stated his last bowel movement was the previous day. RN (b)(6);(b)(7)(C) noted SAMIMI's dinner intake at 5:00 p.m. was 50 percent. RN (b)(6);(b)(7)(C) noted SAMIMI had signs and symptoms of withdrawal, but no tremors or seizures. RN (b)(6);(b)(7)(C) nursing plan was to continue monitoring the detainee and encourage food and nutritional intake.⁸¹

On November 25, 2017, SAMIMI refused all three meals and declined both recreation and a shower.⁸² At an undocumented time, RN (b)(6);(b)(7)(C) spoke with SAMIMI, and he complained of abdominal pain at a level six, with weakness, nausea, and vomiting. SAMIMI's vital signs were all within normal limits, with the exception of a mildly-elevated blood pressure. SAMIMI's heart, lungs, and abdomen were normal, and he reported having his last bowel movement the previous day.⁸³ RN (b)(6);(b)(7)(C) did not document whether he gave the detainee any medications.

At 6:30 p.m., RN (b)(6);(b)(7)(C) noted that SAMIMI was lying in bed and stated he did not sleep the previous night. SAMIMI's vital signs were all within normal limits with the exception of a slightly-elevated blood pressure.⁸⁴ RN (b)(6);(b)(7)(C) completed a CIWA which resulted in a score of 17 based on SAMIMI's nausea/vomiting, tremors, anxiety, and paroxysmal sweating.⁸⁵ In her note, RN (b)(6);(b)(7)(C) documented she gave the detainee Phenergan for complaint of nausea and instructed SAMIMI to pick up his trash, clean his room and to stay up as much as possible during the day. RN (b)(6);(b)(7)(C) did not record administration of Phenergan on the MAR.⁸⁶

On November 26, 2017, SAMIMI refused all three meals and declined both recreation and a shower.⁸⁷

At 12:00 p.m., RN (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) spoke with SAMIMI, and SAMIMI complained of having pain all over but did not report a pain level. SAMIMI was alert and oriented, his lung sounds were clear, and heart and abdominal assessments were normal. SAMIMI's vital signs were within normal limits with the exception of an abnormally-elevated pulse rate. RN (b)(6);(b)(7)(C) did not observe any vomiting. SAMIMI's speech was slurred, and RN (b)(6);(b)(7)(C) observed he appeared unsteady but gained steadiness when she encouraged him to walk. SAMIMI did not recall his last bowel movement and was uncertain of the last time he ate. RN (b)(6);(b)(7)(C) nursing assessment was "possible withdrawal," and her nursing plan included continuation with his plan of care and monitoring his food intake.⁸⁸

⁸¹ See GEO Medical Observation Nursing Progress Record by RN Muiru, dated November 24, 2017.

⁸² See GEO Medical Housing Unit Log, dated November 25, 2017.

⁸³ See GEO Medical Observation Nursing Progress Record by RN Aboye, dated November 25, 2017.

⁸⁴ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated November 25, 2017.

⁸⁵ Creative Corrections notes RN (b)(6);(b)(7)(C) incorrectly calculated the CIWA score. The correct total was 13 which, according to the form, indicates moderate alcohol withdrawal. However, Creative Corrections also notes that per the form, a score of 15 or higher indicates severe alcohol withdrawal, and even though the form, which does not dictate a threshold for provider notification, prudent nursing practice called for RN (b)(6);(b)(7)(C) to contact Dr. (b)(6);(b)(7)(C) for the score she understood to be 17.

⁸⁶ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated November 25, 2017.

⁸⁷ See GEO Medical Housing Unit Log, dated November 26, 2017.

⁸⁸ See GEO Medical Observation Nursing Progress Record by RN Aboye, dated November 26, 2017.

At 6:40 p.m., RN (b)(6);(b)(7)(C) completed a CIWA and took SAMIMI's vital signs, which were all within normal limits. The total score as tabulated by RN (b)(6);(b)(7)(C) was 19 based on the detainee's level of anxiety, nausea and vomiting, tremors, and paroxysmal sweats.⁸⁹ As noted above, the threshold for severe alcohol withdrawal is 15.⁹⁰ RN (b)(6);(b)(7)(C) did not notify Dr. (b)(6);(b)(7) of the CIWA score.

During RN (b)(6);(b)(7)(C) assessment, SAMIMI complained of feeling very weak, nauseated, and the inability to eat. RN (b)(6);(b)(7)(C) noted SAMIMI attempted to rise up on his knees during the encounter but fell over because he was so weak. RN (b)(6);(b)(7)(C) noted SAMIMI had not eaten lunch or dinner, and that she told him that because he was so weak, he would only receive Phenergan. She also told him that following medication pass, she would assess how he was feeling. RN (b)(6);(b)(7)(C) instructed the medical officer to take him to the TV room with food and water.⁹¹

Officer (b)(6);(b)(7)(C), the medical officer, stated she convinced SAMIMI to go to the TV room after telling him that RN (b)(6);(b)(7)(C) would not give him Ativan until he got up and moved around. Officer (b)(6);(b)(7)(C) left SAMIMI in the TV room for approximately 40 minutes during which time she cleaned his cell. At approximately 8:45 p.m., Officer (b)(6);(b)(7)(C) found SAMIMI knocking on the TV room window, urgently requesting to use the bathroom because he was sick. Officer (b)(6);(b)(7)(C) unlocked and opened the door, and SAMIMI walked quickly back to this room.⁹²

After SAMIMI returned to his room, he rested for a few moments and then ate half a cookie and half an orange at RN (b)(6);(b)(7)(C) prompting. After he ate, she administered his medications. She documented that his nursing plan was over-the-counter Pepto-Bismol⁹³ 30 mg at night for three days and continued monitoring in medical observation.⁹⁴ At 9:28 p.m., after returning to the TV room, SAMIMI sat in a wheelchair at the rear of the room and had his feet up on the table in front of him. At 9:30 p.m., SAMIMI removed his feet from the table and slowly slid from the wheelchair onto the floor. He then covered himself with a blanket. Officer (b)(6);(b)(7)(C) entered the room and turned the lights on. She spoke with SAMIMI, and he sat up, then stood and returned to the wheelchair. He put both of his feet on the table as Officer (b)(6);(b)(7)(C) left, turning the light off.⁹⁵

On November 27, 2017, SAMIMI did not wake up to eat breakfast, did not eat lunch or dinner, and declined recreation and a shower.⁹⁶

⁸⁹ When scores applied were re-tabulated, Creative Corrections determined that the RN made an addition error. The correct score was 16.

⁹⁰ See GEO Alcohol Withdrawal Assessment and Treatment Flowsheet, dated November 18-26, 2017.

⁹¹ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated November 26, 2017.

⁹² ERAU notes RN (b)(6);(b)(7)(C) stated SAMIMI "ran" back to his room which indicated less weakness and made her suspect he may have been exaggerating his earlier symptoms.

⁹³ Pepto-Bismol is an over-the-counter medication for loose stools. See Exhibit 1.

⁹⁴ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated November 26, 2017.

⁹⁵ See GEO CCTV footage, dated November 26, 2017.

⁹⁶ See GEO Medical Housing Unit Log, dated November 27, 2017.

At 1:00 a.m., RN (b)(6);(b)(7)(C) heard SAMIMI yelling for the nurse because he was unable to relax. RN (b)(6);(b)(7)(C) gave SAMIMI Ativan, which she administered intramuscularly to his right gluteal muscle.⁹⁷

As logged by the medical officer, at 6:59 p.m., SAMIMI asked a nurse for ice, and the nurse denied the request. At that same time, SAMIMI informed the medical officer that he was on a hunger strike.⁹⁸ GEO Policy 614, Hunger Strikes, states, “Detainees declaring and/or identified as being on a Hunger Strike (missed 9 consecutive meals) will be monitored daily.” SAMIMI’s record contains no documentation that either medical or security staff initiated daily monitoring in accordance with the policy.

At 7:00 p.m., LPN (b)(6);(b)(7)(C) documented that SAMIMI refused to eat dinner and requested stronger medications. SAMIMI’s vital signs were within normal limits. LPN (b)(6);(b)(7)(C) encouraged SAMIMI to eat and drink.⁹⁹

On November 28, 2017, SAMIMI accepted breakfast and lunch but refused dinner, recreation, and a shower.¹⁰⁰ Shortly after 11:00 a.m., SAMIMI collapsed in the hallway on his way to a follow-up mental health appointment with (b)(6);(b)(7)(C)

DCDF CCTV footage documented the following sequence of events:

- At 11:13 a.m., as SAMIMI’s door opened and he approached the threshold with an officer, a nurse with a pill cart stopped in front of the door blocking the line of sight to SAMIMI and the officer. Once the nurse moved the pill cart, the camera showed SAMIMI lying face down on the floor just inside his door.
- At 11:14 a.m., the nurse who was with the pill cart walked down the corridor toward the camera and returned a few moments later with a mobile vital signs monitor. She leaned down to assist SAMIMI who was still on the floor.
- At 11:15 a.m., RN (b)(6);(b)(7)(C) walked down the corridor and leaned down toward SAMIMI.
- At 11:16 a.m., RN (b)(6);(b)(7)(C) pulled SAMIMI up to a standing position. SAMIMI’s knees appeared to buckle, but he remained upright.
- At 11:17 a.m., SAMIMI, with an unidentified nurse holding his right arm and RN (b)(6);(b)(7)(C) on his left, walked down the corridor toward the camera where they were met by Dr. (b)(6);(b)(7)(C) who appeared to speak with SAMIMI. The nurses and SAMIMI then turned around and headed back toward his room while Dr. (b)(6);(b)(7)(C) went into to Dr. (b)(6);(b)(7)(C) office.

RN (b)(6);(b)(7)(C) documented SAMIMI sustained no injuries during this incident. He also noted that SAMIMI reported not having eaten regularly in eight days due to nausea and requested stronger medications to combat his withdrawal symptoms. SAMIMI’s vital signs were within normal limits with the exception of an abnormally elevated pulse rate and very slightly elevated blood

⁹⁷ ERAU Interview with RN (b)(6);(b)(7)(C) dated December 09, 2017. RN (b)(6);(b)(7)(C) erroneously documented in her progress note that she administered the Ativan intramuscularly to the right coccyx.

⁹⁸ See GEO Medical Housing Unit Log, dated November 27, 2017.

⁹⁹ See GEO Medical Progress Note by LPN (b)(6);(b)(7)(C) dated November 27, 2017.

¹⁰⁰ See GEO Medical Housing Unit Log, dated November 28, 2017.

pressure. SAMIMI denied any pain. RN (b)(6);(b)(7) nursing assessment included dehydration, and the detainee's nutritional needs not being met. The nursing plan was to continue to monitor and administer medications as ordered. RN (b)(6);(b)(7) educated SAMIMI on the need to make an effort to eat and drink. RN (b)(6);(b)(7) also wrote, "no matter his actions, stronger meds unavailable."¹⁰¹ RN (b)(6);(b)(7) explained that he included this notation to make the point to SAMIMI that he was not helping himself by his actions (refusing meals and purposefully falling) and that he needed to cooperate because he was not going to get methadone.¹⁰²

After SAMIMI's fall, Dr. (b)(6);(b)(7)(C) discussed SAMIMI's state with Dr. (b)(6);(b)(7)(C) and they agreed that SAMIMI was not stable enough to proceed with his mental health follow-up appointment that day. Dr. (b)(6);(b)(7)(C) assured Dr. (b)(6);(b)(7)(C) that medical was monitoring SAMIMI's vital signs and that SAMIMI had experienced a few good days and that his laboratory results looked good. Dr. (b)(6);(b)(7)(C) stated SAMIMI would remain in medical observation as he underwent withdrawal, and when he stabilized enough to have a coherent conversation, he would return to the mental health clinic.¹⁰³

Suicide Attempt

At approximately 8:45 p.m., Officer (b)(6);(b)(7)(C), the medical officer on duty, entered the anteroom of SAMIMI's cell to perform a security round. When she looked through the window, she observed SAMIMI with a dark blue sheet tied around his neck.¹⁰⁴ Officer (b)(6);(b)(7)(C) reached for the radio on her duty belt so she could call an emergency. Discovering the radio was dead, she hurried to the officer's station and used the telephone to call central control for assistance. She returned to the cell, alerting nursing staff along the way that there was an emergency. Officer (b)(6);(b)(7)(C) opened the cell door, and the responding medical and security staff removed the sheet from around the SAMIMI's neck, despite some resistance from him in the process. Officer (b)(6);(b)(7)(C) stated she heard someone say SAMIMI would be placed on suicide watch, so she left to make preparations. Her preparations included setting up the officer's table and constant watch logbook outside the suicide prevention cell, and retrieving a suicide resistant smock and blanket for issuance to the detainee.¹⁰⁵ Lieutenant (b)(6);(b)(7)(C) confirmed that Dr. (b)(6);(b)(7)(C) placed SAMIMI on constant suicide watch which was "started immediately."¹⁰⁶

DCDF CCTV footage documents the following sequence of events:

- At 8:44:58 p.m., SAMIMI, who was sitting cross legged on his bed, took a blue sheet from his bed and placed it around his neck from behind. He then crossed each end over the other and tightened the sheet by pulling with each arm.
- At 8:46:16 p.m., Officer (b)(6);(b)(7)(C) entered the camera's view at the end of the hallway and entered the outer door into the anteroom outside SAMIMI's cell.

¹⁰¹ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated November 28, 2017.

¹⁰² ERAU Interview with RN (b)(6);(b)(7)(C) dated December 09, 2017.

¹⁰³ See GEO Medical Progress Note by Dr. (b)(6);(b)(7)(C) dated November 28, 2017.

¹⁰⁴ See GEO General Incident Report by Officer (b)(6);(b)(7)(C) dated November 28, 2017.

¹⁰⁵ ERAU Interview with Officer (b)(6);(b)(7)(C) dated December 11, 2017.

¹⁰⁶ See GEO General Incident Report (Supervisor's Notes) by Officer (b)(6);(b)(7)(C) dated November 28, 2017.

- At 8:46:33 p.m., Officer (b)(6);(b)(7)(C) exited the outer door into the corridor and walked to the nurses' station approximately ten feet away. She motioned to the nurse to come to the door. The nurse opened the door at 8:46:54 p.m.
- At 8:47:25 p.m., Officer (b)(6);(b)(7)(C) walked back to the officer's station, approximately 10 feet from the nurses' station, holding her radio in her left hand. She looked at the monitor on her desk displaying camera views of the cells and picked up the phone.
- At 8:48:14 p.m., Officer (b)(6);(b)(7)(C) hung up the phone, returned to SAMIMI's cell and opened the outer door at 8:48:32.
- At 8:49:12 p.m., Nurse Aboye and an unidentified officer entered the cell. RN (b)(6);(b)(7)(C) and Officer (b)(6);(b)(7)(C) entered behind them. Nurse (b)(6);(b)(7)(C) and the first officer removed the sheet from around SAMIMI's neck as he struggled briefly and tried to push them away. Several more officers arrived. SAMIMI spoke with the staff as his property and linens were removed from the cell. He was seated on the bed, cross-legged and leaned forward with his hands on his forehead.
- At 8:51:18 p.m., RN (b)(6);(b)(7)(C) picked up SAMIMI's Styrofoam meal container, which appeared to contain a full meal, and looked inside.
- At 8:51:25 p.m., an officer removed SAMIMI's property bin from the room, and RN (b)(6);(b)(7)(C) opened the meal container and showed it to the detainee.
- At 8:51:41 p.m., SAMIMI shook his head no, and RN (b)(6);(b)(7)(C) set the container on the floor at the end of the bed. RN (b)(6);(b)(7)(C) then departed, leaving SAMIMI alone with the cell door left open. SAMIMI remained seated cross-legged on the bed, leaning forward with his hands on his forehead.
- At 8:55:29 p.m., Lieutenant (b)(6);(b)(7)(C) entered the cell. SAMIMI spoke to the Lieutenant in an animated way, gesturing with his arms and hands, pointing at his head and throwing his arms wide open.
- At 8:58:28 p.m., Lieutenant (b)(6);(b)(7)(C) left the cell.
- At 9:01:49 p.m., an officer entered the cell and spoke to SAMIMI.
- At 9:02:30 p.m., SAMIMI swung his legs onto the floor and sat up. The officer then assisted SAMIMI to his feet and held his left arm as they walked out of the cell.
- At 9:03:08 p.m., Officer (b)(6);(b)(7)(C) re-entered the cell and placed the property bin back into the empty cell. She then removed what appeared to be a pillow case or cloth from behind the bed.¹⁰⁷

RN (b)(6);(b)(7)(C) called Dr. (b)(6);(b)(7)(C) to notify him of the incident. Dr. (b)(6);(b)(7)(C) gave seven verbal orders:¹⁰⁸

1. Suicide level 1 with one-on-one monitoring;
2. Suicide gown, suicide blanket, suicide pillow;
3. Finger foods with paper spork;
4. Ten sheets of toilet paper at a time;
5. One small book or Bible;
6. No underwear, no bed sheet;
7. Mental health appointment.

¹⁰⁷ See GEO CCTV footage, dated November 28, 2017.

¹⁰⁸ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated November 28, 2017.

Security staff placed SAMIMI on level 1 suicide watch with constant, one-on-one monitoring. Medical and security staff took SAMIMI to cell 527 which is the designated suicide watch cell and has a motion-activated camera installed that only records when there is movement inside the cell.¹⁰⁹ The door has a window in the top half and a pipe sensor in the middle. To the right of the door is a large viewing window. Bolted to the center of the floor inside the cell is a concrete bed slab. A stainless steel toilet and sink combination fixture is in the back left corner of the cell. A camera is mounted at the back of the cell near the ceiling and shows a view of the bed, toilet and cell door and window.

The desk for the officer assigned to constant watch was positioned immediately outside the large viewing window and can be seen from the camera inside the cell. The officer was required to log the activity of the detainee every five minutes in the Constant Watch Logbook (separate from the Medical Unit Logbook) and not allowed to leave the post without being properly relieved. Per the ICE PBNDS 2011(revised 2016), detainees placed on suicide watch are to receive eight-hour checks by clinical staff and daily mental health treatment by a qualified clinician. However, there were no medical record entries documenting any encounters with a health care professional between the time SAMIMI was placed on suicide watch and 11:00 a.m. the next morning. Nurse/clinician welfare checks were not conducted every eight hours as required by the ICE PBNDS.

On November 29, 2017, an officer notated SAMIMI accepted his breakfast tray but did not make notations regarding lunch or dinner, or whether he refused or accepted a shower or recreation. At 10:58 a.m., ERO Deportation Officer (b)(6);(b)(7)(C) entered the Medical Unit to conduct staff-detainee communication.¹¹⁰ At 11:00 a.m., Dr. (b)(6);(b)(7)(C) MD, completed an initial psychiatric evaluation with SAMIMI via tele-psychiatry. Dr. (b)(6);(b)(7)(C) documented that SAMIMI complained of inability to sleep, constant vomiting, sweating, and shaking. He denied other opiate symptoms of yawning, tears, and diarrhea. He also denied suicidal intent.

Dr. (b)(6);(b)(7)(C) observed that SAMIMI's CIWA score consistently increased over time and noted that medical staff reported SAMIMI had tremors and frequently requested stronger medication. Dr. (b)(6);(b)(7)(C) listed what to expect with opiate withdrawal, including a notation that it is generally not life-threatening, although dehydration is possible. She also addressed the unsuitability of using the CIWA instead of an opiate withdrawal instrument. Her findings included orientation to person, place, time, and situation; appropriateness of rapport; disheveled appearance with poor grooming, dress, and body odor;¹¹¹ anxious, irritable mood; expansive affect; and coherent, appropriate speech.¹¹²

Dr. (b)(6);(b)(7)(C) discussed symptoms and treatment of mental illness, the frequency of follow-up, prescribed medications and potential side effects, and explained SAMIMI's access to mental

¹⁰⁹ ERAU Interview with Security Chief (b)(6);(b)(7)(C) dated December 11, 2017.

¹¹⁰ See GEO Medical Housing Unit Log, dated November 29, 2017.

¹¹¹ Dr. (b)(6);(b)(7)(C) description of the detainee's body odor was likely reported to her by RN (b)(6);(b)(7)(C).

¹¹² See GEO Initial Psychiatric Evaluation by Dr. (b)(6);(b)(7)(C) dated November 29, 2017.

health services. She also documented medication consent forms were reviewed and signed.¹¹³ Dr. (b)(6);(b)(7)(C) entered nine orders:¹¹⁴

1. Push fluids for 15 days;
2. Discontinue Ativan;
3. Clonidine 0.1 mg orally three times daily for four days, then clonidine 0.1 mg twice daily for four days, then 0.1 mg every night for four days, then stop;
4. Hydroxyzine¹¹⁵ 50 mg three times daily as needed for anxiety for 15 days.
5. Imodium¹¹⁶ 2 mg after each loose stool, total daily dose not to exceed 16 mg as needed for three days;
6. Trazodone¹¹⁷ 100 mg orally every night as needed for sleep for 15 days, then decrease to 50 mg every night for 15 days, then stop;
7. Offer Ensure with each meal for seven days;
8. COWS monitoring for ten days;¹¹⁸
9. Level 2 suicide watch.

RN (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) noted Dr. Chambless' orders that same day and accurately transcribed the medications to SAMIMI's MAR. At 11:20 a.m., RN (b)(6);(b)(7)(C) conducted a nursing round during which SAMIMI complained of nausea. SAMIMI's vital signs were within normal limits, with the exception of an elevated heart rate. RN (b)(6);(b)(7)(C) did not document administration of anti-nausea medication. ERAU notes this was the first documented nursing round after SAMIMI's suicide attempt, more than 14 hours prior.

At 2:18 p.m., the medical officer documented SAMIMI was transitioned to level 2 suicide watch which required monitoring checks with corresponding notations to the Constant Watch Logbook every 15 minutes. The logged 15 minute checks through the remainder of the day primarily documented that SAMIMI was sleeping or lying on his bed. However, the officer logged at 10:15 p.m., 10:30 p.m., and 11:00 p.m., that SAMIMI requested ice water, but was told by RN (b)(6);(b)(7)(C) that he should get water from the sink in his cell.

On November 30, 2017, SAMIMI did not accept any meals and did not shower or go to recreation.¹¹⁹ At 1:00 a.m., RN (b)(6);(b)(7)(C) documented that SAMIMI had blood on his nose, the sleeve of his right arm, and in his mouth, which he spit onto the floor.¹²⁰ Officers and medical staff cleaned SAMIMI and the cell.¹²¹ She completed a full nursing assessment, during which she noted the blood appeared to be coming from SAMIMI's nose. After he was cleaned up and provided new clothes, his vital signs were repeated and were within normal limits. RN

¹¹³ SAMIMI's medical record did not contain a signed consent form for use of the psychiatric medications, Trazadone.

¹¹⁴ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated November 29, 2017.

¹¹⁵ Hydroxyzine is a medication used to treat anxiety, nausea and vomiting. See Exhibit 1.

¹¹⁶ Immodium is a medication to treat loose stools or diarrhea. See Exhibit 1.

¹¹⁷ Trazodone is a medication used to treat anxiety, depression, and sleeplessness. See Exhibit 1.

¹¹⁸ No COWS was ever completed after ordered by (b)(6);(b)(7)(C)

¹¹⁹ See GEO Medical Housing Unit Log, dated November 30, 2017.

¹²⁰ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated November 30, 2017.

¹²¹ See GEO Constant Watch Log, dated November 30, 2017.

(b)(6);(b)(7)(C) nursing plan included offering SAMIMI water every two hours while awake, continuing to monitor him, and notifying the morning staff of the nursing plan.¹²²

At 2:00 a.m., RN (b)(6);(b)(7)(C) documented that SAMIMI rested off and on, and that he occasionally screamed, ‘Nurse, nurse,’ before falling back asleep. SAMIMI’s vital signs were all within normal limits. An officer assigned to SAMIMI’s suicide watch logged that SAMIMI screamed from 4:30 a.m. to 5:15 a.m., and again at 6:57 a.m. when he asked for ice water. The officer noted that a nurse (identity unknown) denied SAMIMI ice water and stated he could drink water [from the sink] like everyone else.¹²³

According to a progress note by RN (b)(6);(b)(7)(C) SAMIMI refused to allow her to take his vital signs at 9:22 a.m., and at 9:25 a.m. refused to cooperate with a nursing assessment. At 11:57 a.m., SAMIMI was evaluated by Dr. (b)(6);(b)(7)(C) in a tele-psychiatry encounter. SAMIMI complained of feeling stressed and depressed and stated that he would rather die than stay in the facility due to needing methadone which he was on for 28 years. Dr. (b)(6);(b)(7)(C) reminded SAMIMI mood symptoms were normal during withdrawal and that he would feel better over time. No psychosis was identified. Dr. (b)(6);(b)(7)(C) plan was to continue SAMIMI on level 2 suicide watch, continue the medication protocol ordered by Dr. (b)(6);(b)(7)(C) and evaluate SAMIMI again in one day.¹²⁴

At 5:37 p.m., SAMIMI had a legal call which ended at 6:15 p.m.¹²⁵ According to HSA (b)(6);(b)(7)(C) GEO transferred the call to the medical officer’s desk, but neither the officer nor medical staff documented the call. HSA (b)(6);(b)(7)(C) stated he overheard SAMIMI converse on the telephone, and the detainee answered questions quickly and coherently.¹²⁶ After the call, RN (b)(6);(b)(7)(C) observed that SAMIMI appeared more upbeat.¹²⁷

On December 1, 2017, SAMIMI did not accept breakfast or lunch but accepted dinner. He did not shower or attend recreation.¹²⁸ At 4:00 a.m., RN (b)(6);(b)(7)(C) logged an interaction with SAMIMI from earlier that morning. She documented SAMIMI slept through the night until 3:30 a.m. when he was observed talking to himself, trying to drink from toilet, falling to the floor, and rolling on the ground. She wrote that the medical officer accompanied her into the cell to prevent injury and offer water. As noted, a few minutes later SAMIMI was asleep. Her nursing plan was to continue to monitor SAMIMI every 15 minutes. SAMIMI’s vital signs were all within normal limits.¹²⁹ ERAU notes officers did not log the incident in either the Medical Unit or Constant Watch Logbook, nor did they write incident reports.

¹²² See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated November 30, 2017.

¹²³ See GEO Constant Watch Log, dated November 30, 2017.

¹²⁴ See GEO Medical Progress Note by Dr. (b)(6);(b)(7)(C) dated November 30, 2017.

¹²⁵ See GEO Constant Watch Log, dated November 30, 2017.

¹²⁶ ERAU Interview with HSA (b)(6);(b)(7)(C) dated December 09, 2017. HSA (b)(6);(b)(7)(C) also stated that the lucidness with which SAMIMI spoke on the phone led him to believe the detainee was exaggerating the severity of his withdrawal symptoms.

¹²⁷ ERAU Interview with RN (b)(6);(b)(7)(C) dated December 09, 2017.

¹²⁸ See GEO Medical Housing Unit Log, dated December 1, 2017.

¹²⁹ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated December 1, 2017.

DCDF CCTV footage documents the following sequence of events:¹³⁰

- At 3:17 a.m., SAMIMI lay on his mattress on the floor of his cell (he moved the mattress to the floor from the bed slab at an unknown time).
- At 3:21 a.m., SAMIMI unsteadily sat up, took his cup and reached for the sink above the toilet. Before reaching the sink, he collapsed to the floor on his side. As he collapsed, SAMIMI's arm hit the toilet and his cup fell out of his hand and into the toilet. He retrieved the cup, lifted it up to the sink, and then brought it toward his mouth. Before reaching his mouth, the cup fell out of his hand and back into the toilet. SAMIMI slumped beside the toilet, with his hand in the toilet, as he tried to fish the cup out a second time. After approximately one minute, SAMIMI pulled his hand out of the toilet, wiped it on his blanket, and continued to lay slumped next to the toilet.
- At 3:23 a.m., SAMIMI attempted to pull himself into a sitting position but quickly fell back to the floor, and did not appear to have the strength to sit. An officer entered the cell and assisted SAMIMI into a sitting position, but SAMIMI toppled over to his right side, and narrowly missed hitting his head on the concrete wall. After falling over, SAMIMI positioned himself on his back, and the officer motioned with his hand toward the door.
- At 3:26 a.m., the officer exited the cell but returned at 3:28 a.m. with a cup of water which he placed on the concrete bed slab before exiting the cell again.
- At 3:30 a.m., SAMIMI pulled himself into a sitting position, took the cup of water from the bed slab, sipped it, and set it on the floor before slumping back to the floor.
- At 3:31 a.m., RN (b)(6);(b)(7)(C) entered the cell with a cup, and SAMIMI sat up resting his head on the bed slab. RN (b)(6);(b)(7)(C) rubbed SAMIMI's head, held the cup out to him, but before taking the cup, SAMIMI fell back to the floor. RN (b)(6);(b)(7)(C) moved to help him, temporarily blocking the camera's view of the detainee.
- At 3:32 a.m., Officer (b)(6);(b)(7)(C) entered the cell with another officer. The two officers and RN (b)(6);(b)(7)(C) grabbed ahold of SAMIMI's legs and arms and slid him onto the mattress away from the toilet.
- At 3:33 a.m., Officer (b)(6);(b)(7)(C) removed a Styrofoam meal container and returned to stand by the toilet.
- At 3:34 a.m., RN (b)(6);(b)(7)(C) re-entered the cell with the mobile blood pressure machine and placed the cuff on the detainee's arm.
- At 3:35 a.m., Officer (b)(6);(b)(7)(C) handed the detainee a cup of water.
- At 3:39 a.m., RN (b)(6);(b)(7)(C) removed the blood pressure cuff from the detainee's arm and wheeled the blood pressure machine out of the cell.
- At 3:40 a.m., Officer (b)(6);(b)(7)(C) and RN (b)(6);(b)(7)(C) re-entered the cell and the nurse placed an additional blanket over SAMIMI.
- At 3:41 a.m., all staff left the cell.

RN (b)(6);(b)(7)(C) stated during interview that she was very concerned about SAMIMI after this incident, as he had yet to be seen by a physician and was very weak. She stated that when SAMIMI asked for more medications during the prior days, it led her to believe he was drug-seeking, but she noted he was never belligerent when asking for medications. She also stated

¹³⁰ See GEO CCTV footage, dated December 1, 2017.

that because his vital signs were consistently normal, she did not believe a visit to the hospital was justifiable, but noted that in retrospect, she should have sent him to the hospital. ERAU notes other nurses interviewed, as well as Dr. (b)(6);(b)(7)(C) cited SAMIMI's normal vital signs as a reason they did not believe his condition was critical or requiring notification to Dr. (b)(6);(b)(7)(C). Creative Corrections advises that the clonidine may have been responsible for controlling SAMIMI's blood pressure.

After this encounter, RN (b)(6);(b)(7)(C) did not make a referral to Dr. (b)(6);(b)(7)(C). At 8:50 a.m., Supervisory Detention and Deportation Officer (SDDO) (b)(6);(b)(7)(C) entered the medical unit to conduct staff-detainee communication.¹³¹ SDDO (b)(6);(b)(7)(C) stated he did not speak with SAMIMI during this visit because the detainee was on suicide watch and was sleeping. He stated that although he never met the detainee, he recalled DCDF reporting at a weekly meeting that SAMIMI was a methadone user and was on suicide watch.¹³²

At 9:15 a.m., RN (b)(6);(b)(7)(C) was escorting SAMIMI to the tele-psychiatry office when, according to RN (b)(6);(b)(7)(C),¹³³ SAMIMI threw himself out of the wheelchair and landed on the floor face first.¹³⁴ SAMIMI sustained a nosebleed and urinated on himself. RN (b)(6);(b)(7)(C) applied pressure to SAMIMI's nose with gauze until the bleeding stopped. RN (b)(6);(b)(7)(C) took SAMIMI's vital signs which were within normal limits. RN (b)(6);(b)(7)(C) stated he was unable to obtain a blood pressure reading because SAMIMI would not stay still. RN (b)(6);(b)(7)(C) also stated SAMIMI was uncooperative, attempted to grab RN (b)(6);(b)(7)(C) with his bloody hands, and was spitting. Officer (b)(6);(b)(7)(C), who was present during this incident, stated SAMIMI asked RN (b)(6);(b)(7)(C) for assistance getting into the wheelchair, but RN (b)(6);(b)(7)(C) declined and told SAMIMI he could get into the wheelchair on his own. Officer (b)(6);(b)(7)(C) stated SAMIMI lowered himself slowly into the wheelchair, but fell out of it on the way to the appointment. Officer (b)(6);(b)(7)(C) noted SAMIMI did not attempt to break his fall.

Dr. (b)(6);(b)(7)(C) approached SAMIMI shortly after his fall from the wheelchair and ordered that SAMIMI be placed back into the suicide watch cell.¹³⁵ Dr. (b)(6);(b)(7)(C) confirmed that he did not witness the incident but based on what was described by RN (b)(6);(b)(7)(C) he believed SAMIMI intentionally threw himself to the floor. He stated he returned SAMIMI to level 1 suicide watch because the action could be interpreted as a suicidal gesture.¹³⁶ SAMIMI did not have his tele-psychiatry appointment that day, but medical staff scheduled an appointment with Dr. (b)(6);(b)(7)(C) psychologist, for the following day.¹³⁷

At 9:44 p.m., Officer (b)(6);(b)(7)(C), the constant watch officer, documented that with his Lieutenant's permission, he opened SAMIMI's door to give the detainee water. His entries thereafter

¹³¹ See Medical Unit Logbook, dated December 1, 2017.

¹³² ERAU Interview with SDDO (b)(6);(b)(7)(C), dated December 10, 2017.

¹³³ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated December 1, 2017.

¹³⁴ Neither the Medical Unit nor the Constant Watch Logbook documents this incident.

¹³⁵ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated December 1, 2017.

¹³⁶ ERAU Interview with Dr. (b)(6);(b)(7)(C) dated December 10, 2017. However, the Constant Watch Logbook does not include an entry documenting SAMIMI's change in status to level 1 suicide watch. However, monitoring entries in the Constant Watch Logbook do switch from every 15 minutes to every five minutes at 10:00 a.m., consistent with level 1 procedures.

¹³⁷ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated December 1, 2017.

DETAINEE DEATH REVIEW – Kamyar SAMIMI, JICMS # (b)(7)(E)

document SAMIMI yelling intermittently, and at 10:29 p.m., he logged that SAMIMI appeared to spit up blood. Officer (b)(6);(b)(7)(C) notified the medical officer who notified a nurse. SAMIMI's medical record does not show a related nursing encounter on this time and date.

At 11:17 p.m., Officer (b)(6);(b)(7)(C) relieved Officer (b)(6);(b)(7)(C). During shift change, Officer (b)(6);(b)(7)(C) informed Officer (b)(6);(b)(7)(C) that SAMIMI refused his meals and did not sleep much during his shift. At 11:34 p.m., Officer (b)(6);(b)(7)(C) logged that SAMIMI complained of stomach pain and that nurses were not available. At 11:44 p.m., Officer (b)(6);(b)(7)(C) logged that RN (b)(6);(b)(7)(C) visited SAMIMI, took his vital signs, and gave him medications.

In an incident report,¹³⁸ Officer (b)(6);(b)(7)(C) documented that throughout his shift SAMIMI got up every few minutes complaining of stomach pains. Officer (b)(6);(b)(7)(C) noted he alerted medical staff on six different occasions that SAMIMI was in pain and was requesting more medication, though he did not note whether medical staff responded on any of these occasions. At one point, SAMIMI asked Officer (b)(6);(b)(7)(C) to bring his medicine and then vomited into the toilet. Officer (b)(6);(b)(7)(C) stated he notified the medical officer to alert nursing staff, and that the nurse who came to check on SAMIMI noticed the detainee was incontinent of urine. Officers removed SAMIMI's wet mattress from the cell and Officer (b)(6);(b)(7)(C) cleaned the cell with the assistance of another officer.¹³⁹

Lieutenant (b)(6);(b)(7)(C), the supervisor on duty the night of December 1, 2017, recalled Officer (b)(6);(b)(7)(C) contacting him regarding SAMIMI, and reporting to the medical unit to check on the detainee himself. Lieutenant (b)(6);(b)(7)(C) reported to a nurse that officers were concerned about SAMIMI, specifically that the detainee was suffering, and the nurse stated Dr. (b)(6);(b)(7)(C) was aware of SAMIMI's status and planned to see the detainee. Lieutenant (b)(6);(b)(7)(C) stated that he decided not to call 911 for SAMIMI when he learned Dr. (b)(6);(b)(7)(C) was informed of the detainee's state.¹⁴⁰

In a progress note completed at 5:00 a.m. on December 2, 2017, RN (b)(6);(b)(7)(C) noted that during the prior evening, SAMIMI screamed for nurses and complained of abdominal pain. At an undocumented time, she took his vital signs which were within normal limits with the exception of a lowered oxygen level. She did not obtain SAMIMI's pain level. SAMIMI's lungs were clear, and his bowel sounds were normal. She noted that several times during the night, SAMIMI screamed that he was unable to breathe, and that nurses gave him a rebreather,¹⁴¹ which he pulled off and went back to sleep. At 3:30 a.m., SAMIMI woke up a third time screaming for Zantac and an injection for nausea. She took SAMIMI's vital signs again and all were within normal limits.¹⁴² RN (b)(6);(b)(7)(C) gave SAMIMI 4 mg of Zofran for nausea

¹³⁸ See Officer (b)(6);(b)(7)(C) Incident Report, signed January 5, 2018. Officer (b)(6);(b)(7)(C) did not date his incident report, but stated during interview that he completed it in mid-December of his own volition, though he did not remember the exact date that he wrote or submitted it.

¹³⁹ See GEO General Incident Report by Officer (b)(6);(b)(7)(C) reviewed by his supervisor January 5, 2018.

¹⁴⁰ ERAU Interview with Lieutenant (b)(6);(b)(7)(C) dated December 11, 2017.

¹⁴¹ A rebreather is a mask with an attached reservoir bag that saves one third of a person's exhaled air, while the rest of the air gets pushed out through side ports covered with a one-way valve. This allows the person to rebreathe some of the carbon dioxide exhaled, which acts as a way to stimulate breathing. See Exhibit 1.

¹⁴² A body temperature was not obtained.

intramuscularly, per verbal order of Dr. (b)(6);(b)(7)(C) RN (b)(6);(b)(7)(C) noted that SAMIMI did not receive his nighttime dose of Trazodone.¹⁴⁴

December 2, 2017 – Day of Death

SAMIMI ate half his breakfast at approximately 5:27 a.m.¹⁴⁵ At 7:06 a.m., Officer (b)(6);(b)(7)(C) assumed the Constant Watch Officer post. He logged that SAMIMI ate some food at 10:15 a.m., but at 10:35 a.m. screamed that he had stomach pain and was vomiting. At 10:50 a.m., when SAMIMI continued to scream, Officer (b)(6);(b)(7)(C) called Lt. (b)(6);(b)(7)(C)¹⁴⁶

As reported by both Officer (b)(6);(b)(7)(C), at approximately 11:00 a.m., a nurse asked Officer (b)(6);(b)(7)(C) to take SAMIMI to an appointment with Dr. (b)(6);(b)(7)(C) Psychologist. The medical officer, and Officer (b)(6);(b)(7)(C) refused, and told the nurse SAMIMI was too unstable to move, and he did not want to risk moving the detainee on his own.¹⁴⁷ Officer (b)(6);(b)(7)(C) stated during interview that SAMIMI had noticeably declined from the previous day and that he continually checked to make sure the detainee was still breathing. Officer (b)(6);(b)(7)(C) asked a nurse to help move SAMIMI, and RN (b)(6);(b)(7)(C) arrived with a wheelchair. Officer (b)(6);(b)(7)(C) and RN (b)(6);(b)(7)(C) lifted SAMIMI into the wheelchair, but once he was seated, the detainee stiffened and slid out of the wheelchair. Officer (b)(6);(b)(7)(C) and RN (b)(6);(b)(7)(C) moved SAMIMI back to the mattress, laid him on his back, and SAMIMI pulled his blanket over his head. Officer (b)(6);(b)(7)(C) remained at SAMIMI's cell while Officer (b)(6);(b)(7)(C) left the scene to wash his arm of a substance from SAMIMI's face which brushed against him during the maneuvers.¹⁴⁸

Officer (b)(6);(b)(7)(C) stated she called for RN (b)(6);(b)(7)(C) and reentered SAMIMI's cell at 11:02 a.m. when she heard the detainee make a choking sound.¹⁴⁹ When RN (b)(6);(b)(7)(C) returned, he turned SAMIMI on his side, and the detainee vomited.¹⁵⁰ Officer (b)(6);(b)(7)(C) observed blood clots in the vomit, which she pointed out to RN (b)(6);(b)(7)(C) and then told the nurse to call Dr. (b)(6);(b)(7)(C). Officer (b)(6);(b)(7)(C) exited the cell and contacted Lieutenant (b)(6);(b)(7)(C)¹⁵² and requested the Lieutenant come to medical.¹⁵³

¹⁴³ Although (b)(6);(b)(7)(C) documented the verbal order in her progress note, the order was never authenticated by Dr. (b)(6);(b)(7)(C). Additionally, the order, as documented, was incomplete, as it did not specify whether it was a stat, as-needed, or regularly-scheduled dose.

¹⁴⁴ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated December 2, 2017.

¹⁴⁵ See Lieutenant (b)(6);(b)(7)(C) email to facility leadership, December 2, 2017.

¹⁴⁶ See GEO Constant Watch Log, dated December 2, 2017.

¹⁴⁷ Officer (b)(6);(b)(7)(C) stated he was assigned to constant watch the previous day and was aware of the incident where SAMIMI struggled to get water and appeared be drinking from the toilet, as well as the incident when SAMIMI fell from his wheelchair. Officer (b)(6);(b)(7)(C) stated when he informed nursing staff that SAMIMI appeared to be in an extremely weakened condition, the nurses responded that the detainee was faking or exaggerating his symptoms. GEO CCTV footage on this date shows the detainee in a very weak condition, resting in a kneeling position with his head on his mattress until Officer (b)(6);(b)(7)(C) and RN (b)(6);(b)(7)(C) moved him, stumbling as he moved to the door and then collapsing before Officer (b)(6);(b)(7)(C) and RN (b)(6);(b)(7)(C) assisted him into the wheelchair.

¹⁴⁸ ERAU Interview with Officer (b)(6);(b)(7)(C) dated December 09, 2017.

¹⁴⁹ ERAU Interview with Officer (b)(6);(b)(7)(C) dated December 09, 2017.

¹⁵⁰ ERAU Interview with RN (b)(6);(b)(7)(C) dated December 11, 2017.

¹⁵¹ ERAU Interview with Officer (b)(6);(b)(7)(C) dated December 09, 2017.

¹⁵² Lieutenant (b)(6);(b)(7)(C) was the Watch Commander for the 7:00 a.m. to 3:00 p.m.

¹⁵³ ERAU Interview with Officer (b)(6);(b)(7)(C) dated December 09, 2017.

RN (b)(6);(b)(7)(C) stated that he returned to SAMIMI's cell after officers informed him SAMIMI was vomiting, repositioned SAMIMI on his side as the detainee vomited, and then instructed the officers to clean the vomit and keep their eye on detainee.¹⁵⁴ RN (b)(6);(b)(7)(C) stated the vomit consisted of stomach contents only and that there was no blood. After leaving the cell, RN (b)(6);(b)(7)(C) stated he decided to call Dr. (b)(6);(b)(7)(C) to recommend that SAMIMI be transferred to a hospital where his needs would be better managed. RN (b)(6);(b)(7)(C) stated he did not consider calling 911 as he did not deem the situation an emergency. RN (b)(6);(b)(7)(C) stated he left messages on Dr. (b)(6);(b)(7)(C) home and mobile phones asking for a return call.¹⁵⁵ Dr. (b)(6);(b)(7)(C) stated during interview that he did not receive the messages.¹⁵⁶

At 11:06 a.m., Lieutenant (b)(6);(b)(7)(C) arrived, accompanied by Officer (b)(6);(b)(7)(C).¹⁵⁷ Lieutenant (b)(6);(b)(7)(C) looked in the cell and observed SAMIMI lying on his right side on a mattress on the floor. He noted SAMIMI's eyes were open, and he looked pale. The Lieutenant stated it was obvious SAMIMI was in crisis and noted there was vomit on the side of SAMIMI's face, and the detainee had urinated and was breathing heavily. The Lieutenant told the officers SAMIMI needed an ambulance and then proceeded to the nurses' station and told RN (b)(6);(b)(7)(C) SAMIMI needed an ambulance. The RN replied that he left messages for Dr. (b)(6);(b)(7)(C) and was trying to reach the HSA. Lieutenant (b)(6);(b)(7)(C) then used another phone in medical to call Central Control, and at 11:10 a.m., directed Officer (b)(6);(b)(7)(C), the control officer, to call 911.¹⁵⁸ Officer (b)(6);(b)(7)(C) left the area to prepare for the hospital transport.¹⁵⁹

After instructing the Central Control Officer to call 911, Lieutenant (b)(6);(b)(7)(C) returned to SAMIMI's cell and told SAMIMI that an ambulance was on the way. Lieutenant (b)(6);(b)(7)(C) stated he observed vomit on and near SAMIMI's face and a substance that looked like blood on the floor. The Lieutenant then went to the armory to issue weapons to Officers (b)(6);(b)(7)(C) and (b)(6);(b)(7)(C) whom he assigned to accompany SAMIMI to the hospital. Lieutenant (b)(6);(b)(7)(C) also assigned perimeter patrol Officer (b)(6);(b)(7)(C) to report to the perimeter gate to escort the paramedics into the facility.

At 11:16 a.m., the Aurora Fire Department (AFD) dispatched a team consisting of two Emergency Medical Technician (EMT) paramedics and two EMT basic responders, who arrived at the facility at 11:18 a.m.¹⁶⁰ Officer (b)(6);(b)(7)(C) opened the perimeter gates for the EMS responders and escorted them through the intake area and into medical.¹⁶¹

¹⁵⁴ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated December 2, 2017.

¹⁵⁵ ERAU Interview with RN (b)(6);(b)(7)(C) dated December 11, 2017.

¹⁵⁶ ERAU Interview with Dr. (b)(6);(b)(7)(C) dated December 10, 2017.

¹⁵⁷ GEO CCTV footage shows Lieutenant (b)(6);(b)(7)(C) and Officer (b)(6);(b)(7)(C) arriving on scene and looking in the cell at 11:07 a.m.

¹⁵⁸ RN (b)(6);(b)(7)(C) documented that he then called HSA (b)(6);(b)(7)(C) who ordered that 911 be called. RN (b)(6);(b)(7)(C) stated that after speaking with HSA (b)(6);(b)(7)(C) he went back to the cell area and found Lieutenant (b)(6);(b)(7)(C) was there. He told the detainee that he received the order for SAMIMI to go to the hospital, whereupon the lieutenant asked if the detainee could "support his own weight." When told he could not, the lieutenant called 911 for him. RN (b)(6);(b)(7)(C) account of events leading to calling for an ambulance is inconsistent with Lieutenant (b)(6);(b)(7)(C) and not supported by any other evidence, written or reported.

¹⁵⁹ ERAU Interview with Lieutenant (b)(6);(b)(7)(C), dated December 09, 2017.

¹⁶⁰ See Aurora Fire Department EMS Patient Care Report, dated December 2, 2017.

¹⁶¹ ERAU Interview with Officer (b)(6);(b)(7)(C), dated December 09, 2017.

According to the AFD report, the EMTs found SAMIMI “lying prone in the holding cell with emesis on the mattress.” He was unresponsive and pulseless with no obvious signs of trauma. The EMTs gave SAMIMI cardiopulmonary resuscitation (CPR) and put a Basic Life Support airway¹⁶² in place. SAMIMI had “coffee ground type emesis” in his airway, and the EMTs continuously suctioned to clear the airway. The EMTs administered epinephrine and continued CPR, which was momentarily delayed when they moved SAMIMI from the floor onto a gurney and out to the ambulance.¹⁶³ The EMTs reported SAMIMI had agonal¹⁶⁴ respirations at a rate of two per minute, and their monitor showed him to be in asystole.¹⁶⁵ They gave SAMIMI a total of nine rounds of CPR, and he remained in asystole until the eighth round, when he transitioned to ventricular fibrillation,¹⁶⁶ The EMTs shocked SAMIMI once, but at the next heart rhythm check, he was back in asystole.¹⁶⁷

(b)(6);(b)(7)(C) Lieutenant (b)(6);(b)(7)(C) escorted the EMS responders to the ambulance, and the ambulance left the facility at 11:40 a.m. for the emergency room at the University of Colorado Health Medical Center (UCMC).¹⁶⁸ Officer (b)(6);(b)(7)(C) rode in the ambulance in the front passenger seat and Officer (b)(6);(b)(7)(C) followed in a chase vehicle. The ambulance arrived at the University of Colorado Medical Center at 11:45 a.m.¹⁶⁹ Upon arrival at the UCMC Emergency Room (ER), SAMIMI had fixed pupils and was in asystole. The ER physician’s preliminary diagnosis was cardiac arrest. ER personnel noted SAMIMI had black vomit on his face and in his airway suggestive of a possible gastro-intestinal bleed.¹⁷⁰

At 12:02 p.m., SAMIMI was pronounced dead by UCMC physician Dr. (b)(6);(b)(7)(C).¹⁷¹ At 2:32 p.m., hospital staff moved SAMIMI’s body to the morgue, and Officers (b)(6);(b)(7)(C) and (b)(6);(b)(7)(C) returned to the facility.¹⁷²

Post-Death Events

On December 6, 2017, at approximately 10:00 p.m., an autopsy was performed on SAMIMI by Dr. (b)(6);(b)(7)(C) of the Adams & Broomfield County Coroner’s Office. Dr. Cina recorded SAMIMI’s cause of death as undetermined, but documented SAMIMI had chronic obstructive pulmonary disease (emphysema) and gastrointestinal bleeding, which likely contributed to his death. Dr. (b)(6);(b)(7)(C) documented he could not rule out methadone withdrawal as the cause of death,

¹⁶² Basic Life Support airway is an instrument inserted through the mouth, extending into the airway, to keep the airway open. See [Exhibit 1](#).

¹⁶³ See Aurora Fire Department EMS Patient Care Report, dated December 2, 2017.

¹⁶⁴ Agonal breathing refers to labored breathing, characterized by gasping. See [Exhibit 1](#).

¹⁶⁵ Asystole, also known as cardiac flat line, is the absence of heart contractions. See [Exhibit 1](#).

¹⁶⁶ Ventricular fibrillation is a life-threatening heart rhythm that results in a rapid, inadequate heartbeat. See [Exhibit 1](#).

¹⁶⁷ See Falk Rocky Mountain Emergency Medical Services (EMS) Patient Care Report, dated December 2, 2017. The Falk Rocky Mountain EMS also reported to DCDF and documented events reported by the ADF EMTs.

¹⁶⁸ See GEO Medical Transport Log, dated December 2, 2017.

¹⁶⁹ See GEO Medical Transport Log, dated December 2, 2017.

¹⁷⁰ See UC Health/AMC Emergency Report, dated December 2, 2017.

¹⁷¹ See GEO Medical Progress Note by RN (b)(6);(b)(7)(C) dated December 2, 2017.

¹⁷² See GEO Medical Transport Log, dated December 2, 2017.

but noted that deaths due to methadone withdrawal are rare. He noted SAMIMI had no injuries and no evidence of dehydration.¹⁷³

Following SAMIMI's death, DCDF's Warden, Johnny Choate, personally met with each member of security staff who interacted with SAMIMI and provided information on employee assistance services. However, Warden Choate only met informally with nursing staff and did not refer them to employee assistance.

ERO sent a letter to SAMIMI's next-of-kin on December 11, 2017, notifying her of his death.

DCDF reviewed SAMIMI's death on December 6, 2017, at a Monthly Safety Committee Meeting.¹⁷⁴ CCTV footage was not reviewed for this review. The resulting report stated that both medical and security staff acted properly and in accordance with policy and procedures on December 2, 2017.¹⁷⁵

On December 18, 2017, a committee composed of Warden Choate, Dr. (b)(6);(b)(7)(C) HSA (b)(6);(b)(7)(C) RN (b)(6);(b)(7)(C) and a GEO quality assurance representative, (b)(6);(b)(7)(C) completed a Multi-Level Mortality Review of SAMIMI's death. No security or ERO staff participated in the review, and the committee did not review any CCTV footage as part of the review. The committee's findings are purportedly based on the detainee's medical record and reports from medical staff; however, the report contains many statements that are inconsistent with the medical record, and findings that are unsupported by the medical record, which are examined in detail by Creative Corrections. The Mortality Review resulted in one recommendation: "Re-emphasize to all nursing staff, use your clinical judgment and call 911 when presented with a life or death situation." The committee also identified as strength: "Quick initiation of withdrawal protocol. Monitoring of detainee while on withdrawal protocol."¹⁷⁶

MEDICAL CARE AND SECURITY REVIEW

ERAU reviewed the medical care SAMIMI was provided at DCDF, as well as the facility's efforts to ensure that he was safe and secure while detained at the facility. ERAU found deficiencies in DCDF's compliance with certain requirements of the ICE PBNDS 2011 (revised 2016).

1. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(B), which states, "All facilities shall provide medical staff and sufficient support personnel to meet these standards."
 - At the time of SAMIMI's detention, DCDF had vacancies in key medical personnel, including a Director of Nursing and a midlevel provider, for longer than six months.

¹⁷³ See Exhibit 3: Adams & Broomfield County Autopsy Report by Dr. (b)(6); dated December 6, 2017.

¹⁷⁴ Key Safety Committee participants include the Warden, Associate Warden, Chief of Security, Training Administrator, Maintenance Supervisor, HSA, Food Service Manager.

¹⁷⁵ See GEO Safety Committee Meeting Minutes by Safety Manager (b)(6);(b)(7)(C) dated December 6, 2017.

¹⁷⁶ See GEO Multi-Level Mortality Review, dated December 18, 2017.

2. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(G)(12), which states, “Each detention facility shall have and comply with written policy and procedures for the management of pharmaceuticals, to include...(12) documentation of accountability for administering or distributing medication in a timely manner, and according to licenses provider orders.”
 - DCDF’s physician wrote prescription orders for treatment of withdrawal, for up to three times daily, as needed, for anxiety, restlessness, sleeplessness, nausea, and pain. In spite of frequent and progressive complaints of these symptoms, the Medication Administration Record (MAR) shows nurses administered only five of 42 doses for anxiety, 21 of 42 doses for restlessness/sleeplessness, 17 of 42 doses for pain, and only four of 42 doses for nausea and vomiting.
 - Neither nursing notes nor the MAR consistently document times nurses administered medications to SAMIMI, making it difficult for nurses on subsequent shifts to know when SAMIMI was due for his next dose.
3. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(J), which states, “Where there is a clinically significant finding as a result of the initial screening, an immediate referral shall be initiated and the detainee shall receive a health assessment no later than two working days from the initial screening.”
 - The intake nurse’s documentation of SAMIMI’s possible early opioid withdrawal did not result in an initial provider assessment within two working days of intake.
4. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(K), which states, “Detainees experiencing severe or life-threatening intoxication or withdrawal shall be transferred immediately to an emergency department for evaluation. Once evaluated, the detainee will be referred to an appropriate facility qualified to provide treatment and monitoring for withdrawal, or treated on-site if the facility is staffed with qualified personnel and equipment to provide appropriate care.”
 - DCDF medical staff failed to transfer SAMIMI to an ER even though he exhibited life-threatening withdrawal symptoms during the week following his intake.
5. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(M), which states, “Each facility’s health care provider shall conduct a comprehensive health assessment, including a physical examination and mental health screening, on each detainee within 14 days of the detainee’s arrival unless more immediate attention is required due to an acute or identifiable chronic condition.”
 - DCDF failed to complete an initial physical assessment during the 15 days SAMIMI was housed at the facility, in part due to the absence of a midlevel provider.
6. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(N), which states, “Where a detainee has a serious medical or mental health condition or otherwise requires special or

close medical care, medical staff shall complete a Medical/Psychiatric Alert form (IHSC-834) or equivalent, and file the form in the detainee’s medical record.”

- Medical staff did not complete a Medical/Psychiatric alert for SAMIMI.
7. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(R), which states, “An initial dental screening shall be performed within 14 days of the detainee’s arrival. The initial dental screening may be performed by a dentist or a properly trained qualified health provider.”
- Medical staff did not schedule SAMIMI for a dental screening examination.
8. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(T), which states, “An on-call physician, dentist, and mental health professional or designee, are available 24 hours per day.”
- Nurses reported difficulty reaching Dr. (b)(6);(b)(7) outside of his working hours. On the day of SAMIMI’s death, the physician did not answer or return two phone calls.
9. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(U), which states, “Distribution of medication (including over the counter) shall be performed in accordance with specific instructions and procedures established by the HSA, in consultation with the CMA. Written records of all prescribed medication given to or refused by detainees shall be maintained.”
- A nurse who administered Phenergan on November 25, 2017, did not document it on the MAR.
 - Nurses documented administration of Ativan in nursing notes on November 17, 20, 21, and 27, but did not make corresponding notations on the MAR.
 - A nurse did not document SAMIMI’s refusal of clonidine on December 1, 2017, in the nursing notes, and did not complete a refusal form.
 - A nurse did not notate an administration of clonidine on December 2, 2017, on the MAR.
10. ICE PBNDS 2011 (revised 2016), *Medical Care*, Section (V)(X), which states, “The facility administration and clinical medical authority shall ensure that the Field Office Director is notified as soon as practicable of any detainee housed at the facility who is determined to have a serious physical or mental illness or to be pregnant, or have medical complications related to advanced age, but no later than 72 hours after such determination. The written notification shall become part of the detainee’s health record file.”
- DCDF did not notify the Field Office Director that SAMIMI was withdrawing from methadone and that his condition was deteriorating.

- Had ERO field office personnel been notified and engaged early into his treatment by medical personnel, a critical opportunity to engage with security and medical staff concerning SAMIMI's treatment could have been leveraged. Prompt engagement of the local field office would likely help to ensure a comprehensive and adequate review of events and assist in identifying areas needing both immediate and/or long-term corrective action, before response becomes critical.

11. ICE PBNDS 2011 (revised 2016), Medical Care, Section (V)(AA), which states, "Prior to the administration of psychotropic medication, a separate documented informed consent, that includes a description of the medication's side effects."

- An informed consent specific to the anti-depressant/sedative Trazodone was not completed and signed by the detainee.

12. ICE PBNDS 2011 (revised 2016), *Significant Self Harm and Suicide Prevention and Intervention*, Section (V)(F), which states, "All suicidal detainees placed in an isolated confinement setting will receive continuous one-to-one monitoring, welfare checks at least every 8 hours conducted by clinical staff, and daily mental health treatment by a qualified clinician."

- Nursing staff did not conduct a welfare check on SAMIMI during the 14 hours between his placement on suicide watch and his evaluation via tele-psychiatry. The next nursing round occurred 15 hours later.

AREAS OF CONCERN

Although not reflective of any violation of the requirements of the detention standards, ERAU noted the following violations of GEO policy related to medical care.

- 905-A, *Medical Observation*, which states, "1) Nursing personnel will complete the Medical Observation Nursing Progress Record, form 142.6, upon entry to the observation area; 2) Subsequent assessments will be documented on each shift; 3) A patient status note and vital signs will be performed and documented every two hours unless directed otherwise by the physician/designee and will be entered into a progress note; 4) Detainees admitted for 24 hour observation may, but are not required to, receive skilled nursing intervention; 5) The responsible clinician/designee will write a daily note for each detainee on medical observation for more than 24 hours."
 - Nurses did not consistently perform nursing assessments each shift.
 - Nurses did not take SAMIMI's vital signs every eight hours, as ordered by the physician.
 - The clinician or designee did not write daily notes.

- 905-A, *Medical Observation*, which states, “Detainees will not be housed in the medical observation area for more than 24 hours without a physician’s/designee’s order, Medical observation may be continued for three (3) consecutive 24-hour periods (up to 72 hours). Each renewal of medical observation after 24 hours must be approved through notification of the responsible physician/designee. Medical observation may not be continued beyond 72 hours. After 72 hours the detainee must be admitted as an infirmary patient in an institution with an infirmary, discharged to the general population, or transferred to a higher level of care.”
 - Dr. (b)(6);(b)(7) did not renew his orders for SAMIMI’s placement in medical housing.
- 902, *Alcohol and Drug Assessment and Treatment*, which states, “Detainees at risk for progression to more severe levels of intoxication or withdrawal will be kept under constant observation in the infirmary/medical observation area by health care staff, and whenever detainee symptoms are observed, a physician will be consulted promptly. Detainees experiencing severe, life-threatening intoxication or withdrawal will be immediately transferred to an acute care facility.”
 - On at least two occasions, November 30 and December 1, 2017, the night nurse failed to call the physician, despite her observation of SAMIMI’s serious clinical symptoms.

ERAU identified the following violations of GEO post orders.

- Medical Utility Officer Post Order, section (V)(D)(10), *General Duties*, which states, “All necessary documentation shall be completed prior to the end of your work period and forwarded to your immediate supervisor.”
 - Officer (b)(6);(b)(7)(C) did not complete an incident report documenting significant events prior to the end of his shift.
- Medical Utility Officer Post Order, section (V)(1)(c), *Level 1 One-on-One Observation*, which states, “The detainee will be given appropriate suicide preventative clothing. All non-suicide preventative articles of clothing will be removed from the detainee. This will include the detainee’s undergarments.”
 - When placed again on Level 1 observation/suicide watch on December 1, 2017, security staff allowed SAMIMI to retain his detention uniform.
- Medical Utility Officer Post Order, section (V)(1)(g), *Level 1 One-on-One Observation*, which states, “The Cell door will not be opened under any circumstances without two officers being present and the on duty Shift Supervisor being notified of the need to open the cell.”

- On several occasions, officers opened the cell door when SAMIMI was on Level 1 suicide watch without another officer present or without any documentation a shift supervisor was notified and gave approval.

ERAU identified the following violations of GEO policy concerning safety and security.

- DCDF Policy 11.2.31, *Permanent Logs and Reports*, sections (A) and (H), which state respectively, “Logs will be maintained to reflect the activities of each post or other area on a shift-by-shift basis and to document emergency situations, unusual incidents, and other pertinent information regarding detainees and activities on the post”; and “Make written and oral reports as necessary.”
 - Officer (b)(6);(b)(7)(C) did not log in the Constant Watch Logbook SAMIMI’s move from Level 2 to Level 1 suicide watch.
 - The GEO Suicide Watch Log and Notes, Form #HS-207, lists Level 1 suicide watch as “Constant Observation,” while the DCDF post orders for the Medical Utility Officer refer to Level 1 suicide watch as “Continual Observation.” The GEO Suicide Watch Log and Notes, Form #HS-207, lists Level 2 suicide watch as “Fifteen Minute Checks” while the DCDF post orders for the Medical Utility Officer refer to Level 2 suicide watch as “Constant Observation” requiring 15 minute checks. Per Creative Corrections, ensuring consistency among the forms and post orders will help avoid staff confusion.
 - During his shift from 11:00 p.m. on December 1, to 7:00 a.m. on December 2, 2017, Officer (b)(6);(b)(7)(C) did not document in the Constant Watch Logbook all pertinent information that occurred on the shift.
- The GEO Track system also erroneously documented the date and time of the detainee’s placement on suicide watch.
- DCDF Policy 17.1.2, *Sanitation Procedures*, section (I), Blood or Other Body Fluid, which states, “Following any incident where there is spillage of blood or other body fluids the area shall be sanitized immediately by a member of the health service staff.... Medical staff will utilize ‘Clean-Up Kits’ to clean up any blood and body fluids as well as decontaminate the area.” Security staff is responsible for ensuring the area is secure and that all persons entering the area are donning appropriate personal protective equipment.
 - DCDF currently requires security personnel to clean up bodily fluids such as urine, feces and vomit. Medical personnel only clean spills that contain blood. While the Security Chief believes medical staff should clean any spills in accordance with the policy, the HSA believes that medical staff should only clean spills containing blood. As result of internal disagreement between the Security Chief and the HSA, despite the language of the written policy, the

two disciplines appear to be operating in a tense environment which could adversely affect their communication and responsiveness.

- GEO Policy 614, *Hunger Strikes*, which states, “Detainees declaring and/or identified as being on a Hunger Strike (missed 9 consecutive meals) will be monitored daily.”
 - On November 27, 2017, at 6:59 p.m., the medical officer logged that SAMIMI declared he was on a hunger strike. A supervisor reviewed and signed off on the medical officer’s logbook entries approximately eight hours later. Although the log entry indicates security staff were aware of SAMIMI’s declared hunger strike, neither security nor medical documentation indicate staff initiated monitoring of SAMIMI pursuant to the policy.

ERAU also identified the following area of concerns regarding implementation of opiate withdrawal protocols.

- DCDF holds current NCCHC accreditation but failed to comply with NCCHC standard J-G-07, which states: “Detoxification and withdrawal are best managed by a physician or other medical professional with appropriate training and experience. As a precaution, severe withdrawal symptoms must never be managed outside of a hospital. Deaths from acute intoxication or severe withdrawal have occurred in correctional institutions. In deciding the level of symptoms that can be managed safely at the facility, the responsible physician must take into account the level of medical supervision that is available at all times. Clinical management should also include the use of validated withdrawal assessment instruments, such as the Clinical Opiate Withdrawal Scale or the Objective Opiate Withdrawal Scale in case of opiate withdrawal, and the Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised, in the case of alcohol withdrawal.”
 - Nurses reported they were unfamiliar with the COWS instrument, and were never trained in opioid withdrawal. Nurses’ actions demonstrated a lack of understanding of opioid withdrawal symptoms, including that drug seeking behaviors are expected. Nurses also failed to properly monitor SAMIMI as he withdrew from opioids and to recognize his related life-threatening symptoms.
 - Nurses did not fulfill the psychiatrist’s November 29, 2017 order to complete a daily COWS for SAMIMI.

ERAU identified the following concerns related to administration of medications:

- Nursing notes did not consistently document justification for administration of as needed medications, or an assessment of SAMIMI’s need for medications.
- Nurses sometimes refused medications until the detainee ate, rather than provide anti-nausea medication to enhance his appetite.

- Nurses often failed to document the time of medication administration. Per Creative Corrections, absent documentation of times medications were given, nurses on later shifts could not know when another dose was or was not due. Although speculative, the poor documentation on MARs may have contributed to SAMIMI less than 50 percent of possible doses of medications as needed for anxiety, restlessness, sleeplessness, nausea and pain.
- Nurses erroneously recorded administration of medications on SAMIMI's MAR after he was transported to the hospital.

ERAU identified the following concerns regarding nursing care.

- SAMIMI's intake screening did not address current symptoms of withdrawal as called for on the screening form.
- After intake, nurses did not take SAMIMI's weight again to determine rate of weight loss, which Creative Corrections advises was particularly important given SAMIMI's refusal of meals and inability to keep food down.
- Nurses did not make any entries to SAMIMI's medical record on November 19, 2017.
- Nurses did not maintain SAMIMI's safety through fall prevention. Video showed incidents in which SAMIMI appeared to hit his head or come close to doing so on the floor or against the wall.
- On November 24, 2017, nurses failed to complete a full injury assessment after SAMIMI fainted.
- Although, both medical and security staff described him as disheveled and having a strong body odor during their interviews, the nurses stated they did not encourage SAMIMI to shower.
- Dr. (b)(6);(b)(7)(C) verbal orders for medications issued November 17, 2017, were not authenticated.
- Nursing notes were brief and inadequate, particularly with respect to subjective information.
- Nurses did not write progress notes in SOAPE format.¹⁷⁷

¹⁷⁷ SOAPE charting, a nursing standard of care which provides organized information to other healthcare personnel, addresses subjective information (what the detainee said), objective information (relevant physical examination), assessment (nursing diagnosis based on both subjective and objective information, plan (efforts to resolve, report, or monitor), and education (teaching, directing, and ensuring the patient's full understanding). See Exhibit 1.

- Nurses did not consistently document encounter times.
- Nursing assessments did not consistently document pain levels.
- Nurses did not consistently document the justification for giving as-needed medications.
- Nurses incorrectly documented verbal/telephone orders.
- Nurses did not document completion of assessments for dehydration.

ERAU identified the following concerns related to security documentation.

- While security staff routinely documented that the detainee was not eating meals, it is unclear whether security staff communicated this to medical staff. On six occasions, officers did not make entries to the Medical Housing Unit Log documenting SAMIMI's acceptance or refusal of showers, recreation, and meals. Missed meal entries include both lunch and dinner on November 29, 2017, which, if refused, total seven consecutive meals SAMIMI refused.
- The majority of signatures made by security supervisors and medical staff on the Medical Unit Housing Log forms are illegible. Creative Corrections advises that ensuring the staff documenting rounds are easily identifiable ensures accountability.

ERAU identified the following concerns related to after-action reviews of SAMIMI's death.

- Following SAMIMI's death, facility staff including the Warden, Medical Director, HSA, Quality Assurance Manager, and an RN, discussed the events surrounding the detainee's death at a routine safety meeting and during a facility mortality review. Neither review included viewing of video surveillance footage of the detainee. As a result, conclusions reached during both reviews were based, in part, on incomplete information.

ERAU identified the following concern related to maintenance of security equipment.

- The medical officer had a non-functioning radio when she made a round on November 28, 2017 and encountered SAMIMI. Security equipment should be regularly checked to ensure its operability in the event of an emergency.

APPENDIX 1
SAMIMI VITAL SIGNS

The table below shows SAMIMI's vital signs listed in nursing notes, and blood pressure readings documented in the Blood Pressure Record. Missing readings indicate a nurse did not notate a reading on that date anywhere in SAMIMI's medical record.

DATE	TEMPERATURE	PULSE	RESPIRATIONS	BLOOD PRESSURE	OXYGEN
11/17/2017	97.9	75	21	146/94	
11/17/2017	98.2	94	16	130/94	100
11/17/2017					
11/18/2017	97.1	75	16	104/67	95
11/18/2017	98.0	65	19	110/74	
11/18/2017					
11/19/2017					
11/19/2017					
11/19/2017					
11/20/2017				106/76	
11/20/2017		94	16	130/94	100
11/20/2017					
11/21/2017	97.6	87	16	118/76	95
11/21/2017					
11/21/2017					
11/22/2017	98.2	82	17	108/74	99
11/22/2017					
11/22/2017					
11/23/2017	98.1	82	16	107/74	97
11/23/2017	97.8	76	16	134/93	98
11/23/2017					
11/24/2017	98.2	102	18	128/83	93
11/24/2017	98.8	77	18	129/85	96
11/24/2017					
11/25/2017	97.8	76	16	134/93	98
11/25/2017		91	16	127/93	96
11/25/2017				117/88	
11/26/2017	98	111	16	107/81	99
11/26/2017	97.6	71	16	125/85	96
11/26/2017		92	16	126/78	96
11/27/2017		98	12	124/80	95
11/27/2017					
11/27/2017					
11/28/2017	98.1	107	18	124/91	95
11/28/2017					
11/28/2017					

11/29/2017	97.7	120	16	108/82	100
11/29/2017					
11/29/2107					
11/30/2017	97.6	88	16	100/70	95
11/30/2017	97.8	100	15	101/70	99
11/30/2017				100/76	
12/01/2017		84	16	101/64	96
12/01/2017		94	18		
12/01/2017				112/68	
12/02/2017	98.2	92	17	113/68	94
12/02/2017		100	17	92/68	95

APPENDIX 2

SAMIMI MAR DOCUMENTATION

The table below shows SAMIMI's medication administrations as documented on his MAR.

Date	Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen	Hydroxyzine	Immodium	Trazodone
18-Nov	9:00 a.m.	9:00 a.m. 9:00 p.m.	Given once; time not recorded	None	Given twice; times not recorded	Not Prescribed	Not Prescribed	Not Prescribed
Date	Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen	Hydroxyzine	Immodium	Trazodone
19-Nov	Refused	9:00 a.m. 9:00 p.m.	Given twice; times not recorded	None	Given twice; times not recorded	Not Prescribed	Not Prescribed	Not Prescribed
Date	Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen	Hydroxyzine	Immodium	Trazodone
20-Nov	None	9:00 a.m.; second dose at time not recorded	Given twice; times not recorded	None	Given twice; times not recorded	Not Prescribed	Not Prescribed	Not Prescribed
Date	Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen	Hydroxyzine	Immodium	Trazodone
21-Nov	None	9:00 a.m.	Given once; time not recorded	None	Given once; time not recorded	Not Prescribed	Not Prescribed	Not Prescribed
Date	Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen	Hydroxyzine	Immodium	Trazodone
22-Nov	9:00 p.m.	9:00 a.m. 9:00 p.m.	Given twice; times not recorded	Given once; time not recorded	Given once; time not recorded	Not Prescribed	Not Prescribed	Not Prescribed
Date	Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen	Hydroxyzine	Immodium	Trazodone
23-Nov	9:00 p.m.	9:00 a.m. 9:00 p.m.	Given twice; times not recorded	None	Given once; time not recorded	Not Prescribed	Not Prescribed	Not Prescribed
Date	Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen	Hydroxyzine	Immodium	Trazodone
24-Nov	9:00 p.m.	9:00 a.m. 9:00 p.m.	Given twice; times not recorded	Given once; time not recorded	Given once; time not recorded	Not Prescribed	Not Prescribed	Not Prescribed
Date	Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen	Hydroxyzine	Immodium	Trazodone
25-Nov	None	9:00 a.m. 9:00 p.m.	Given twice; times not recorded	None	Given once; time not recorded	Not Prescribed	Not Prescribed	Not Prescribed

DETAINEE DEATH REVIEW – Kamyar SAMIMI, JICMS # (b)(7)(E)

Date	Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen	Hydroxyzine	Immodium	Trazodone
26-Nov	None	9:00 a.m.	Given once; time not recorded	None	Given once; time not recorded	Not Prescribed	Not Prescribed	Not Prescribed
Date	Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen	Hydroxyzine	Immodium	Trazodone
27-Nov	None	9:00 p.m.	Given once; time not recorded	None	Given once; time not recorded	Not Prescribed	Not Prescribed	Not Prescribed
Date	Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen	Hydroxyzine	Immodium	Trazodone
28-Nov	None	9:00 a.m.	Given once; time not recorded	Given once; time not recorded	Given once; time not recorded	Not Prescribed	Not Prescribed	Not Prescribed
Date	Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen	Hydroxyzine	Immodium	Trazodone
29-Nov	Not Prescribed	9:00 p.m.	None	Given once; time not recorded	None	None	None	None
Date	Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen	Hydroxyzine	Immodium	Trazodone
30-Nov	Not Prescribed	9:00 a.m. 3:00 p.m. 9:00 p.m.	Given once; time not recorded	None	Given twice; times not recorded	None	None	9:00 p.m.
Date	Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen	Hydroxyzine	Immodium	Trazodone
1-Dec	Not Prescribed	9:00 a.m. 3:00 p.m. 9:00 p.m.	9:00 a.m.	3:00 p.m.	9:00 a.m.	9:00 a.m.	None	None

EXHIBITS

1. Creative Corrections Medical and Security Compliance Analysis
2. GEO Medical Intake Screening by LPN (b)(6);(b)(7)(C) dated November 17, 2017.
3. Adams & Broomfield County Autopsy Report by Dr. (b)(6);(b)(7)(C) dated December 6, 2017.

Detainee Death Review: Kamyar SAMIMI, A #22732918
Healthcare and Security Compliance Analysis
Denver Contract Detention Facility
Aurora, Colorado

As requested by the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU), Creative Corrections participated in a review of the death of detainee Kamyar SAMIMI while in the custody of the Denver Contract Detention Facility (DCDF). A site visit was conducted January 9 through 11, 2018 by (b)(6);(b)(7)(C) ERAU Unit Chief, (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) ERAU Inspection and Compliance Specialist and team leader; and Creative Corrections contract personnel (b)(6);(b)(7)(C), Program Manager, (b)(6);(b)(7)(C), Security Subject Matter Expert; and (b)(6);(b)(7)(C) Registered Nurse, Medical Subject Matter Expert. Contractor participation was requested to determine compliance with the ICE 2011 Performance Based National Detention Standards (PBNDS), 2016 revision, governing medical care and security operations.

Included in this report is a case synopsis, description of the facility and its medical services, detention summary, a narrative description of events, and conclusions. The information and findings herein are based on analysis of detainee SAMIMI's medical record and detention file, tour of the intake and medical areas, interviews of staff, and review of policy, video surveillance recordings, and available incident related documentation.

SYNOPSIS

Kamyar SAMIMI was 64 years old when admitted to DCDF on November 17, 2017. He died shortly after transfer to the hospital on December 2, 2017.

During intake screening, SAMIMI reported taking high-dose methadone on a daily basis since sustaining an injury to his back more than 20 years ago. The physician was contacted and ordered housing in medical observation, laboratory testing, vital signs every eight hours, and medications as needed for anxiety, restlessness, sleeplessness, nausea, and pain. The detainee remained in medical housing over the course of the 16-day detention period. The laboratory tests were completed and determined by the physician to be essentially within normal limits. Vital signs, typically taken twice a day during nursing encounters, were also generally within normal limits over the detention period. An assessment instrument for monitoring withdrawal symptoms was not used, and SAMIMI was never evaluated by the physician or other medical provider. Evaluations by mental health providers identified no mental health diagnosis. Nurses administered less than half the as-needed medications ordered.

Starting November 24, 2017, there were multiple incidents suggesting SAMIMI's withdrawal symptoms were worsening and his condition was deteriorating, although medical staff questioned their legitimacy based on their observations and his vital signs. The incidents included SAMIMI appearing to faint while at the door of his cell, collapsing in the hallway while being escorted to a mental health appointment, suicide attempt, and report that he was drinking from the toilet. Video taken in the last 48 hours of SAMIMI's detention shows he was in an extremely weakened condition, unable to stand or sit up, and incontinent of bowel and urine.

On the day of SAMIMI's death, an unsuccessful attempt was made to move SAMIMI to a wheelchair for a mental health appointment. Finding he was too ill, the nurse and officers returned him to his cell. As the nurse attempted contact with the physician by telephone, a lieutenant arrived and directed that an ambulance be called. Emergency Medical Services responders arrived within approximately four minutes and SAMIMI stopped breathing very quickly thereafter. Cardiopulmonary resuscitation was started and continued through his placement in the ambulance and arrival at the emergency room. Resuscitation efforts were unsuccessful, and death was pronounced at 12:02.

The autopsy report documents the cause and manner of death were undetermined.

FACILITY DESCRIPTION

DCDF is privately owned and operated by the GEO Group, Inc. (GEO) of Boca Raton, Florida. The facility holds detainees for ICE and the United States Marshal Service. On the day of detainee SAMIMI's death, the total population of 808 included 73 United States Marshal Service detainees and 735 ICE detainees.

(b)(7)(E)

According to Major (b)(6);(b)(7)(C) Security Chief, officers attend a two week on-site academy and complete one week of on-the-job training before assuming a post alone. A watch commander, typically a lieutenant, is responsible for supervising officers and managing shift operations. During day shift on Fridays and Saturdays, the administrative captain serves as watch commander.

DCDF has maintained accreditation by the American Correctional Association since 1989 and by the National Commission on Correctional Health Care (NCCHC) since 2003. According to the Health Services Administrator (HSA), the next NCCHC survey is scheduled for May 2018.

HEALTH CARE SERVICES

Health care is provided by GEO, supported on a limited basis by subcontractors. The HSA, (b)(6);(b)(7)(C) is a foreign medical graduate who retired from the Federal Bureau of Prisons as a physician assistant. Mr. (b)(6);(b)(7)(C) was hired as HSA for DCDF in March 2016. The Clinical Medical Authority, Dr. (b)(6);(b)(7)(C) provides clinical services and oversight under subcontract with Correctional Care Solutions (CCS). Dr. (b)(6);(b)(7)(C) provides on-site services 40 hours per week and on-call services 24 hours per day, seven days per week. The staffing plan includes one half-time midlevel provider; however, the position has been vacant since July 2017. HSA (b)(6);(b)(7)(C) reported the vacancy has recently been filled.

All nurses are GEO employees. Authorized nursing positions include a full time Director of Nurses (DON), eight full-time and five part-time registered nurses (RN), and seven full-time licensed practical nurses (LPN). The HSA reported the DON position has been vacant for a lengthy period of time due to recruitment challenges. Additional nursing vacancies at the time of the site visit included two LPNs and an RN with designated responsibility for chronic care patients. Nurses work both eight and 12 hour shifts, providing coverage by two nurses at all times. Additional positions authorized by the GEO staffing plan include a registered health information administrator, three medical records clerks, a part-time dental assistant, a full-time x-ray technician, and an administrative assistant. The administrative assistant position was vacant at the time of the site visit.

Mental health services are provided by two part-time psychologists and four as-needed tele-psychiatrists. The psychologists provide services under contract with Registry of Physician Specialists (RPS); the four tele-psychiatrists provide services under three contracts, one with RPS, two with Family Guidance Center, and one with Mind Care Solutions. Dental services are provided by one part-time CCS dentist and the afore-referenced GEO dental assistant.

The DCDF clinic is spacious and well maintained. It has two examination rooms, an urgent care room, pharmacy, laboratory, x-ray area, two-chair dental suite, enclosed nurses' station, medical records office, tele-psychiatry room, biohazard and supply storage closets, and various offices for mental health and administrative staff. There are five observation cells with anterooms, each equipped with negative pressure for respiratory isolation, and one cell designated for suicide watch. The cells have stationary security cameras, footage from which is monitored by the assigned medical officer.

DCDF does not have an electronic medical record system. Nursing encounters are documented on GEO Progress Notes and for patients housed in medical, GEO Medical Observation Nursing Progress Record forms. The standard SOAPE¹ format is used only on the latter.

¹ SOAPE charting, a nursing standard of care which provides organized information to other healthcare personnel, addresses subjective information (what the detainee said), objective information (relevant physical examination),

A review of credential files found all professional licenses and certifications were current and primary source verified.

SUMMARY OF EVENTS

Friday, November 17, 2017

Detainee SAMIMI was transported to DCDF from the ERO office by GEO officers. There is no time stamp on video surveillance footage of the intake area so the exact time of arrival could not be determined; however, the Emergency Notification and Property Disposition Form documents arrival at **4:00 p.m.** Form I-213, Record of Deportable/Inadmissible Alien, noted, "The subject claims good health. Subject takes methadone for back pain." The video shows detainee SAMIMI arrived with four others and was placed in a holding cell where he remained for approximately five hours. According to the intake officer, (b)(6);(b)(7)(C), the delay in initiation of processing was caused by the volume of admissions and releases. Review of video confirmed a high level of activity in the area. Officer (b)(6);(b)(7)(C) stated SAMIMI was let out of the hold room to see a nurse because an officer or another detainee reported he was ill. The video shows him walking without assistance to the medical screening room.

LPN (b)(6);(b)(7)(C) completed the medical and mental health intake screening at **9:30 p.m.** She documented and confirmed during interview that SAMIMI spoke English. Staff interviewed during the site visit consistently reported SAMIMI spoke English fluently. SAMIMI's vital signs were all within normal limits with the exception of an abnormally elevated blood pressure of 146/94. His height was five feet, seven inches tall and his weight was 135 pounds.

Note: 135 pounds is underweight for a man of SAMIMI's height. Arresting Deportation Officer (DO) (b)(6);(b)(7)(C), ERO Fugitive Operations, stated during interview that the detainee appeared very thin, especially compared to a past photograph. Medical and security staff also observed that SAMIMI was very thin when admitted.

LPN (b)(6);(b)(7)(C) documented that SAMIMI reported taking 190 milligrams (mg) of methadone daily and that he was suffering withdrawal symptoms. She did not specify how long he had taken methadone and last use. In addition, she did not complete section 17 of the screening form calling for specifying symptoms of withdrawal²².

assessment (nursing diagnosis based on both subjective and objective information, plan (efforts to resolve, report, or monitor), and education (teaching, directing, and ensuring the patient's full understanding).

²² Early signs of opiate withdrawal include running nose, sweating, tearing, yawning, dilated pupils, and increased temperature. Later signs include loss of appetite, nausea, vomiting, diarrhea, goose flesh, increased blood pressure, increased pulse, restlessness, and severe muscle and joint pain.

Note: No methadone was received with detainee SAMIMI. DO (b)(6);(b)(7)(C) informed the review team that when he arrested SAMIMI at his residence, the detainee was walking to his car and reported he was on his way to his methadone clinic.

During interview of LPN (b)(6);(b)(7)(C) she stated she observed no tremors or other withdrawal symptoms and that SAMIMI was stable and steady on his feet. She recalled that the only symptom SAMIMI reported was anxiety, and that he repeatedly stated he needed methadone for chronic back pain caused by a car accident. LPN (b)(6);(b)(7)(C) documented he reported sharp back pain of level five³ during screening. SAMIMI's substance abuse history included two to three beers occasionally over the past thirty years, cocaine/crack one time weekly over the past twenty years, marijuana once weekly and opium daily twenty years ago. He also reported smoking ten cigarettes a day, his last having been ten hours earlier. In the dental section of the form, LPN (b)(6);(b)(7)(C) documented SAMIMI lost his front teeth in the car accident.

Note: There was no further dental screening or examination during the detention period.

The nursing plan of care directed the detainee's placement on the "blood pressure list" and completion of blood pressure checks three times weekly for two weeks, with provider referral in the event his blood pressure was elevated. As explained by HSA (b)(6);(b)(7)(C) placement on the blood pressure list effectively referred SAMIMI for chronic care evaluation following the period of blood pressure monitoring. LPN (b)(6);(b)(7)(C) cleared SAMIMI for general population; however, RN (b)(6);(b)(7)(C) reported that she directed that he first be brought to the clinic due to his reported withdrawal. RN (b)(6);(b)(7)(C) stated that when she spoke with detainee SAMIMI, he informed her he was taking 190 mg of methadone on a daily basis for detoxification from other drugs, leading her to telephone Dr. (b)(6);(b)(7)(C) for orders (see below).

Note: The reported methadone dosage of 190 mg daily is consistent with information reported to LPN (b)(6);(b)(7)(C) however, LPN (b)(6);(b)(7)(C) documented SAMIMI said methadone was used to address chronic back pain. RN (b)(6);(b)(7)(C) did not document her discussion with SAMIMI; therefore, it cannot be determined whether he gave discrepant information, or if the RN's recollection was inaccurate.

As part of the intake process, SAMIMI signed consent for medical, dental, and mental health services and authorization to obtain health information. In addition, a screening chest x-ray showed no acute cardiopulmonary disease or evidence of active tuberculosis.

Officer (b)(6);(b)(7)(C) reported that she expedited SAMIMI's intake processing when informed he was to go to the clinic. She said he was offered a shower, changed into facility clothing, and his property was inventoried. The inventory form lists a belt and hat, two pair of pants, five pair of

³ Patient report of pain level is based on a standardized scale of zero to ten, with zero signifying no pain and ten signifying the worst pain ever experienced.

socks, one shirt, two t-shirts, two pair of underwear, one pair of shoes, two sweaters and one wallet. He also had \$22 in U.S. currency. The funds were placed into an account for purchase of phone time and commissary. SAMIMI signed receipts for the funds, facility clothing and hygiene supplies. He gave consent to have mail delivered to him at the facility and named (b)(6);(b)(7)(C) as his emergency contact.

A PREA Risk Assessment form was signed by the detainee and a staff member whose signature is not legible. Risk factor checkboxes were left blank in both the yes and no columns, and no score was applied. SAMIMI also signed a form acknowledging that he was apprised of PREA reporting information and received the ICE Sexual Abuse and Assault Awareness Pamphlet.

Detainee SAMIMI was classified medium low using the ICE Custody Classification Worksheet. The rating was approved by a supervisor on November 21, 2017.

RN (b)(6);(b)(7)(C) documented receipt of telephone orders from Dr. (b)(6);(b)(7) at **10:30 p.m.**

Note: RN (b)(6);(b)(7)(C) did not document whether the orders were read back to verify accuracy, and Dr. (b)(6);(b)(7) did not sign to authenticate his verbal orders as required by Colorado law⁴.

The orders were as follows:

1. Stat⁵ laboratory studies to include a complete blood count⁶, comprehensive metabolic panel⁷, thyroid stimulating hormone⁸, and formal urine⁹;

Note: During interview, RN (b)(6);(b)(7)(C) said she drew the blood samples and sent them for laboratory testing the same night. According to the LabCorp report, they were not received until November 20, 2017.

2. Medications, to include:

⁴ Colorado Revised Statutes Title 25 Health § 25-3-111 requires verbal order authentication within 48 hours, unless a read-back and verify process is in place, in which case the authentication must occur within 30 days.

⁵ Stat means immediate.

⁶ A complete blood count is a test that provides information about the various cell concentration in a patient's blood to assist in disease diagnosis.

⁷ A comprehensive metabolic panel is a test that provides information about the status of your metabolism, including kidney and liver function, electrolyte balance, blood glucose, and blood proteins, in order to monitor such conditions as hypertension and diabetes.

⁸ A thyroid stimulating hormone (TSH) test is a blood test that measures the level of this hormone to determine if the thyroid gland is functioning properly.

⁹ A formal urine, or urinalysis, is a test that analyzes the culture and contents of a urine sample.

- Ativan¹⁰ 1 mg intramuscularly up to three times daily as needed for 15 days.

Note: RN (b)(6);(b)(7)(C)s note documents Ativan 1 mg was administered intramuscularly in the right deltoid. Administration of the medication was not recorded on the Medication Administration Record (MAR).

- Clonidine¹¹ 0.1 mg orally up to three times daily as needed for 15 days.
- Cyclobenzaprine¹² 10 mg orally up to three times daily as needed for 15 days.
- Ibuprofen¹³ 800 mg orally up to three times daily as needed for 15 days.
- Phenergan¹⁴ 25 mg orally up to three times daily as needed for 15 days.

3. Hold in medical.
4. Appointments with psychology and physician.

Note: As described below, SAMIMI was seen by the psychologist on November 20, 2017. However, he was not added to Dr. (b)(6);(b)(7)(C) Provider Appointment Log despite the verbal order and clinically significant findings identified during the intake screening. In fact, SAMIMI was not physically examined by the physician during the detention period. During interview of Dr. (b)(6);(b)(7)(C) he shared that initial assessments of detainees with abnormal intake screening findings were completed by the midlevel provider in the past. He said that since the midlevel provider became vacant, RNs have performed all physical examinations. HSA (b)(6);(b)(7)(C) confirmed Dr. (b)(6);(b)(7)(C) does not conduct initial physical examinations and remarked it is likely there were other detainees with significant medical problems whose initial examinations were conducted by RNs.

5. Increase and encourage fluids.
6. Vital signs every eight hours until further notice.

Note: A MAR for vital signs was created specifying they were to be taken every eight hours; however, it remained blank throughout the detention period. RN (b)(6);(b)(7)(C) stated that she noted the vital signs order on the MAR as a reminder to nursing staff. Nurses documented vital signs in their notes and on three occasions (November 25, November 30, and December 1, 2017), recorded blood pressure readings on the Blood Pressure Record. As reflected below and in Appendix 1, nurses took vital signs once or

¹⁰ Ativan is a medication to treat anxiety.

¹¹ Clonidine is a medication with sedating properties, used to treat high blood pressure.

¹² Cyclobenzaprine is a muscle relaxant medication.

¹³ Ibuprofen is a medication to treat pain.

¹⁴ Phenergan is a medication with sedating and pain control properties, used to treat nausea.

twice per day rather than every eight hours. HSA (b)(6);(b)(7)(C) stated during interview that nurses mistakenly understood that vital signs were to be conducted once per shift. Because many worked 12 hour shifts, vital signs were not taken every eight hours as ordered.

Note: SAMIMI was not weighed again following intake, and pulse oxygen saturation was not consistently taken with vital signs. During interview, Dr. (b)(6);(b)(7)(C) stated pulse oxygen saturation and body weight should typically be taken when obtaining vital signs; however, because the laboratory results were normal (see below), he did not believe it was “truly necessary” for nurses to do so in SAMIMI’s case. He also shared his opinion that there is risk involved in having patients whose gait is unsteady walk down the hall and step on a scale.

During discussion of his orders, Dr. (b)(6);(b)(7)(C) stated they were based on GEO’s Clinical Practice Guideline (CPG) for opioid withdrawal. He and HSA (b)(6);(b)(7)(C) both noted the GEO CPG mirrors that of the Federal Bureau of Prisons. Dr. (b)(6);(b)(7)(C) stated he opted not to order an EKG as recommended in the CPG because he thought it more important to have the laboratory tests done. He also opted not to order an HIV test because SAMIMI did not report use of injectable drugs or other high risk behaviors. Asked whether he considered ordering nurse monitoring using an opioid withdrawal assessment instrument, he remarked that such instruments provide guidance but they “are not really protocol.” He added that detainees are typically finished withdrawing in three to four days but because SAMIMI reported use of high dose methadone over several years, his withdrawal was prolonged.

Note: The CPG does not address use of an assessment instrument; however, NCCHC mandates monitoring using validated instruments. The reviewer notes the Clinical Opiate Withdrawal Scale (COWS)¹⁵ is most widely recognized and used, although GEO has a limited instrument titled, “Alcohol/Drug Withdrawal Monitoring Sheet”. Instructions on the Alcohol/Drug Withdrawal Monitoring Sheet direct completion at least twice daily for a minimum of three days. If significant issues are found, the nurse is to notify a clinician and document in the health record. Review of the GEO form found it does not mirror the COWS. Regardless, neither a COWS nor the GEO instrument were completed during SAMIMI’s detention. As discussed below, on four occasions nurses used an instrument specific to alcohol withdrawal.

Note: Nurses reported they have not been trained in opiate withdrawal, although HSA (b)(6);(b)(7)(C) stated opiate withdrawal has been discussed at meetings. No documentation of training in the subject was available, and Dr. (b)(6);(b)(7)(C) stated it is assumed nurses receive adequate training in nursing school.

¹⁵ COWS is a tool used to assign points specifically to symptoms of opiate withdrawal, with total scores indicating the severity of withdrawal. It is not compatible with alcohol withdrawal instruments (e.g. CIWA)

Note: The CPG calls for giving clonidine in doses of 0.1 to 0.2 mg orally three to four times daily as a means of controlling hypertension and somnolence¹⁶, suggesting interval dosing at specific times rather than as needed. Although Dr. (b)(6);(b)(7) ordered administration as needed, the MARs for both clonidine and Ativan set 9:00 a.m., 3:00 p.m., and 9:00 p.m. as the times for administration. As identified below, MAR entries for ordered medications were found by the reviewer to be inconsistent, with times not recorded at all or noted at times which did not align with nursing notes. Asked about the process followed for making MAR entries, RN (b)(6);(b)(7)(C) stated that at least for clonidine, nurses selected whichever of the three set times (9:00 a.m., 3:00 p.m., and 9:00 p.m.) was closest to when they gave SAMIMI a dose. Failure to document the actual time clonidine, Ativan, and other medications are given may result in administration of medication before or after another dose is clinically appropriate.

In addition to addressing dosage and frequency, the CPG states blood pressure and heart rate levels must be obtained prior to each dose of clonidine. The CPG also states the medication is to be withheld if systolic blood pressure¹⁷ falls below 90. Dr. (b)(6);(b)(7)(C) order did not include this guidance. Because nurses took vital signs less than half the time ordered, and because they did not consistently and accurately document the time clonidine and other medications were given, the reviewer was unable to verify whether SAMIMI's blood pressure was checked before giving clonidine. As identified below and in Appendix 1, the detainee's blood pressure was in the normal range when taken, suggesting the clonidine effectively controlled any hypertension that may have been caused by withdrawal.

Note: Standard nursing practice calls for assessment of patient symptoms prior to administration of as-needed medications. In addition, justification must be documented in a nursing note, and administration must be documented in both the note and on the MAR. As noted below, nurses did not consistently document assessment of symptoms to determine the need for medications, and did not consistently document administration on both the MAR and in a nursing note.

Written in the margin of RN (b)(6);(b)(7)(C)'s note documenting Dr. (b)(6);(b)(7)(C) orders was ART Innovative Recovery Clinic, 2925 East Colfax Avenue, Denver, Colorado, with two telephone numbers. RN (b)(6);(b)(7)(C) stated during interview that SAMIMI said he was a methadone patient at this clinic. She wrote the name and address of the clinic in the event Dr. (b)(6);(b)(7) decided to seek SAMIMI's records. As discussed below, Dr. (b)(6);(b)(7) reported to the review team that he attempted to verify the detainee was a patient at the clinic.

¹⁶ Somnolence is a state of feeling drowsy, increasing risk of injury.

¹⁷ Systolic blood pressure is reflected in the top number.

The first nursing round was documented by RN (b)(6);(b)(7)(C) at 10:30 p.m. Asked about the expected frequency of rounds, HSA (b)(6);(b)(7)(C) stated it was implied in Dr. (b)(6);(b)(7)(C) order for vital signs every eight hours that nurses were expected to perform assessments at the same time. Standard nursing practice requires that assessments include documentation of subjective¹⁸ and objective¹⁹ findings and administration of medications as needed, to manage identified symptoms.

Note: As detailed below, nurses documented encounters with SAMIMI only once or twice per day and did not consistently document subjective and objective findings.

On a Medical Observation Nursing Progress Record, RN (b)(6);(b)(7)(C) documented that SAMIMI stated, “I feel terrible.” His vital signs were within normal limits with the exception of a slightly elevated blood pressure of 130/94. He denied chest and abdominal pain but complained of level eight pain.

Note: RN (b)(6);(b)(7)(C) did not document the location or nature of the pain.

RN (b)(6);(b)(7)(C) wrote that SAMIMI reported nausea and vomiting two hours earlier and described his emesis as, “hardly anything” and “greenish” in color. He reported he had a “watery” bowel movement on November 20, 2017, which the reviewer notes was three days after the date of this encounter. RN (b)(6);(b)(7)(C) admitted the date recorded was an error and could not recall the date SAMIMI reported. The assessment noted tremors to his hands and an unsteady gait. The nursing plan was to continue monitoring and encourage fluid intake.

Note: Neither the MAR nor the note documents whether SAMIMI was given medication for his reported level eight pain.

The GEO track form²⁰ shows detainee SAMIMI was placed in medical observation cell 537 at 11:14 p.m. Video surveillance footage of detainee SAMIMI’s entry to the cell shows he walked in unassisted and made his bed without difficulty. The Medical Logbook documents SAMIMI’s assignment at 11:19 p.m. and that his placement made the total unit count four. The Medical Logbook is bound, with numbered pages on which officers sequentially record events on the post and any noteworthy information pertaining to detainees assigned to the unit. Cell 537 is entered through an enclosed anteroom which includes a sink. The door to the cell has a window in the top half, and to the left of the door is another large viewing window. The cell has a single bed on the left, a toilet behind a half wall and a shower behind a full wall. A camera is in the upper left corner of the cell. A monitor on the officer’s desk displays live video feed of the interior of all cells in the clinic. Activities are documented in a Medical Unit Housing Record Log specific to

¹⁸ In the standard SOAP note charting method, subjective information refers to what the patient reports.

¹⁹ Objective information refers to physical assessment findings.

²⁰ The GEO track form shows the time and location of detainee housing assignments.

each detainee. On this form, officers enter yes, no or refused for acceptance of a meal, recreation, and shower, and medical staff and security supervisors document rounds. Recreation in the medical unit consists of time outside the cell, including use of the "TV Room" equipped with a wall-mounted television, table and chair. Entries to detainee SAMIMI's Medical Unit Housing Record are summarized in Appendix 2.

Note: As reflected below and in Appendix 2, SAMIMI's Medical Unit Housing Record Log does not document that he ever accepted the opportunity to shower. While officers would not necessarily have noticed and recorded his use of the shower within cell 537, showering after placement on suicide watch would have necessitated release from the cell to do so and entry in the log by the officer. No officer interviewed recalled SAMIMI ever showering.

Note: Logging yes with respect to a meal signifies acceptance of a tray. Officers do not record whether a detainee consumes all or part of the meal. As noted below and in Appendix 2, SAMIMI's acceptance of meal trays became sporadic starting November 24, 2017. Other documentation indicates that he frequently did not consume meals in whole or in part.

Note: HSA (b)(6);(b)(7)(C) stated he expects nurses to sign the log each day. During interview of RN (b)(6);(b)(7)(C) she stated that the log sheets are on the officer's desk and nurses may miss making entries. In addition, RN (b)(6);(b)(7)(C) stated it is not clear which nurse is responsible to sign the log, the nurse assigned to the area or the nurse who delivers medication. As reflected below and in Appendix 3, nurses made daily entries on the log on all but two occasions. Although the log entries were missed, the medical record documents contact with the SAMIMI.

Officer (b)(6);(b)(7)(C) started detainee SAMIMI's Medical Housing Unit Log after assuming the post for the 11:00 p.m. to 7:00 a.m. shift. On interview, Officer (b)(6);(b)(7)(C) described SAMIMI as very talkative and very thin. She recalled the nurse obtained a blood sample but SAMIMI was unable to provide a urine sample. He asked for Gatorade, which Officer (b)(6);(b)(7)(C) obtained from nurses in powdered version and provided to SAMIMI.

Saturday, November 18, 2017

Medical Housing Unit Log

SAMIMI accepted all three meal trays this date and declined recreation and a shower. Officer (b)(6);(b)(7)(C) stated that when she collected the detainee's breakfast tray, she noted all items were consumed but when she returned to duty for the evening shift, some of the dinner meal remained on the tray. Medical staff signed the log as did a security supervisor. All signatures are illegible.

MAR

Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen
9:00 a.m.	9:00 a.m. 9:00 p.m.	Given once; time not documented	Not given	Given twice; times not documented

Note: Administration of Ativan was not documented in a nursing note.

Note: Ibuprofen may have been given due to complaints of pain during nursing encounters discussed below. The nursing notes for the encounters do not document whether the medication was given, and do not document the justification for giving cyclobenzaprine. The basis for giving clonidine is also not documented as required for as-needed medication; however, the fact that SAMIMI was experiencing symptoms of withdrawal justifies administration of the medication on this and subsequent dates. The conflict is that Dr. (b)(6);(b)(7) ordered clonidine as needed rather than on a scheduled basis. As noted above, the reviewer cannot verify whether SAMIMI's blood pressure was checked before he was given clonidine due to the inconsistent and possibly inaccurate timing of MAR entries.

Vital Signs

Temperature	Pulse	Respirations	Blood Pressure	Oxygen	Weight
97.1	75	16	104/67	95	Not taken
98.0	65	17	110/74	Not taken	Not taken
Not taken	Not taken	Not taken	Not taken	Not taken	Not taken

Medical Record

A GEO Alcohol Withdrawal Assessment and Treatment Flow Sheet (*Clinical Institute Withdrawal Assessment or CIWA*)²¹ was completed at **1:45 p.m.** RN (b)(6);(b)(7)(C) stated during interview that she completed the form but acknowledged she did not enter her initials where required. Vital signs (see the first row of the above table) were within normal limits. A score of seven was determined, indicating the level of alcohol withdrawal did not require medication treatment.

Note: The CIWA is specific to alcohol withdrawal. Although many of the same symptoms are experienced by persons withdrawing from opioids, there are clinical differences which are factored in scores on the respective assessment forms. RN (b)(6);(b)(7)(C) stated during interview that she knows that alcohol and opioid withdrawal are clinically different and that she “must have grabbed the wrong form.”

²¹ CIWA is a tool used to assign points specifically to symptoms of alcohol withdrawal, with total scores indicating the severity of withdrawal. It is not compatible with opiate withdrawal instruments (e.g. COWS).

RN (b)(6);(b)(7)(C) (b)(6);(b)(7)(C) completed a Medical Observation Nursing Progress Record. He did not record the time. During interview, RN (b)(6);(b)(7)(C) guessed that the encounter occurred about 11:00 a.m.; however, his documentation includes reference to times later in the day. Specifically, RN (b)(6);(b)(7)(C) wrote that SAMIMI consumed an unspecified amount of water at **4:40 p.m.** and ate 40 percent of his dinner at **4:50 p.m.** Vital signs exactly matched those documented on the CIWA, suggesting the same set was used. SAMIMI reported his last bowel movement was the previous day. His skin was warm and flushed, and he complained of headache pain at a level six.

Note: RN (b)(6);(b)(7)(C) note does not document whether pain medication was given.

At **6:00 p.m.**, RN (b)(6);(b)(7)(C) completed a Medical Observation Nursing Progress Record. He wrote that SAMIMI reported taking methadone over the past 20 years and that he was experiencing nausea at the time. Vital signs (see second row of the above table) were within normal limits. He denied all pain but appeared pale. With the exception of nausea, no signs or symptoms of withdrawal were noted. SAMIMI reported his last bowel movement was earlier in the day, and that he ate approximately 70 percent of his evening meal. The nursing plan was to continue monitoring.

Note: There is no documentation Phenergan was given to relieve nausea.

Note: RN (b)(6);(b)(7)(C) entry documents SAMIMI consumed 40 percent of the evening meal; RN Muiru entry documents he ate 70 percent. The inconsistency cannot be explained, although it is possible the detainee gave different reports.

A **10:00 p.m.** progress note written by LPN (b)(6);(b)(7)(C) documents SAMIMI stated, "I have pain on my hand and on my back, including my spinal from long time car accident" and that he takes methadone for pain. He was alert and oriented with no shortness of breath or distress observed. He complained of methadone withdrawal symptoms, stating, "My stomach hurts, I am shivering." LPN (b)(6);(b)(7)(C) wrote, "Pass to nurse (b)(6);(b)(7)(C) and nurse (b)(6);(b)(7)(C) contact Dr. (b)(6);(b)(7)(C). During interview, LPN (b)(6);(b)(7)(C) stated RN (b)(6);(b)(7)(C) was the nurse referred to in her note, and that she believed Dr. (b)(6);(b)(7)(C) had been notified.

Note: The medical record documents no contact or attempted contact with Dr. (b)(6);(b)(7)(C) this date.

Note: LPN (b)(6);(b)(7)(C) note does not document whether SAMIMI was given any medication.

Sunday, November 19, 2017

Medical Unit Housing Record

SAMIMI accepted all three meals and declined recreation and a shower. Medical staff signed the log as did a security supervisor. All signatures are illegible.

Medical Unit Logbook

A **7:38 a.m.** entry documents, SAMIMI “x-Ray, withdraw”.

Note: The medical record includes no x-ray report corresponding to this logbook entry.

A **10:40 a.m.** entry documents detainee SAMIMI said he was in a lot of pain and nurses are aware. Nurse (b)(6);(b)(7)(C) was informed at 10:42 a.m. and at 10:47 a.m., reported to the cell and gave medication.

Note: There were no medical record entries this date to corroborate the officer’s entries, although the MAR documents SAMIMI was given pain medication at an unspecified time.

The Telnate Phone Record Report documents that at **6:13 p.m.**, detainee SAMIMI made a free five minute phone call. Reviewers listened to the recording of the call, which was made to an unidentified person. SAMIMI stated he is “dying here” and asked the call recipient to notify his sister so she could post his bond. He also asked what day it was and how long he had been detained. He was told it was Sunday and that he had been there three days. Detainee SAMIMI stated, “I’m a legal resident” and at the end of the call, stated he was housed in medical and that he was “sicker than hell.”

MAR

Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen
Refused	9:00 a.m. 9:00 p.m.	Given twice; times not documented	None documented	Given twice; times not documented

Note: There were no medical record entries documenting the justification for giving medications.

Vital Signs

No vital signs were documented this date.

Medical Record

There were no nursing rounds or progress notes in the medical record this date. HSA (b)(6);(b)(7)(C) could not explain why encounters were not documented.

Monday, November 20, 2017

Medical Unit Housing Record

SAMIMI accepted all three meals. There was no entry documenting whether a shower or recreation was offered and accepted or declined, although the Telmate Phone Record report documents that at 4:49 p.m., SAMIMI attempted a phone call to the same number called on November 19, 2017. There was no answer. The fact that he attempted a call suggests he accepted the offer of his recreation period. Medical staff signed the log as did a security supervisor for each shift. All signatures are illegible.

Note: There is no record of any other non-attorney phone calls attempted or completed by the detainee. Both the logbook and staff recollections confirm he had telephone communications with his attorney. Since attorney calls are not monitored and recorded, they are not placed through the Telmate phone system used for personal calls. Instead, attorney calls are placed on facility phones with staff assistance, and no record is maintained.

MAR

Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen
None documented	9:00 a.m.; second dose at time not documented	Given twice; times not documented.	None documented	Given twice; times not documented

Note: As noted below, RN (b)(6);(b)(7)(C) documented in her note that she gave an injection of Ativan that is not documented on the MAR. The basis for as-needed administration of cyclobenzaprine and ibuprofen is not reflected in nursing notes.

Vital Signs

Temperature	Pulse	Respirations	Blood Pressure	Oxygen	Weight
Not taken	Not taken	Not taken	106/76	Not taken	Not taken
Not taken	94	16	130/94	Not taken	Not taken
Not taken	Not taken	Not taken	Not taken	Not taken	Not taken

Medical Record

A CIWA form was completed at **9:30 a.m.** The form was not initialed or signed, but RN (b)(6);(b)(7)(C) acknowledged completing it. When asked about use of the CIWA, she said she has not been trained in opiate withdrawal monitoring and therefore, is unfamiliar with an appropriate assessment instrument such as the COWS or the GEO form. RN (b)(6);(b)(7)(C) recorded vital signs within normal limits except for a slightly elevated blood pressure (see second row of the above table) and applied points for symptoms of nausea/vomiting, tremors, and paroxysmal sweating, and anxiety.

Note: Although the CIWA was not the proper assessment instrument, the categories in which RN (b)(6);(b)(7)(C) applied points are symptoms of opioid withdrawal. Her application of points documents SAMIMI was experiencing withdrawal symptoms in the referenced categories.

Dr. (b)(6);(b)(7) Psychologist, conducted a mental health evaluation from **1:15 to 1:40 p.m.** Dr. (b)(6);(b)(7) wrote that SAMIMI denied a history of suicidal or homicidal intent, self-harm, alcohol use, domestic violence, sexual assault, or violence toward self or others. SAMIMI said he came to the U.S. when he was 20 years old and attended universities in Colorado and Wisconsin. Prior to detention, he was self-employed as an auto technician. He reported an arrest for cocaine possession 15 years ago and that he “met all requirements.”

Dr. (b)(6);(b)(7) documented SAMIMI reported first use of opium in Iran when he was four years old, explaining that his grandfather, a doctor, administered the narcotic to him for an earache. He said he made a decision to use opium recreationally at the age of 14 while still in Iran. SAMIMI reported he migrated to methadone in 1991 upon recommendation of a mental health professional. He has been taking methadone daily since that time; most recently, five days prior to arrival at DCDF. SAMIMI said his daily dose was 150 mg.

Note: As noted above, documentation by LPN (b)(6);(b)(7) and RN (b)(6);(b)(7)(C) indicates SAMIMI previously reported he was taking 190 mg daily.

Dr. (b)(6);(b)(7) noted SAMIMI was in active withdrawal, complaining of chills, nausea, stomach pain, headache, and body aches. He responded to questions logically and cooperatively. He was fully oriented, exhibited no signs of psychosis, and denied delusions or hallucinations as part of withdrawal. Dr. (b)(6);(b)(7) plan was to continue SAMIMI’s housing in the medical observation unit for continued monitoring of vital signs. He was to return in one week for follow up of his withdrawal status, assess his adjustment to detention, and identify any potential mental health concerns underlying or resulting from the opiate addiction.

During interview, Dr. (b)(6);(b)(7) shared that she is a certified Addictions Specialist III. She offered that her specific knowledge in methadone use and withdrawal is limited, but she readily identified SAMIMI as a patient in opioid withdrawal. She said she did not discuss her observations of SAMIMI’s withdrawal symptoms with medical staff. Asked for other observations, she said she found SAMIMI, “very bright, well-spoken and cooperative,” and that she observed nothing to suggest he was being “dodgy” or manipulative.

A **7:00 p.m.** progress note by RN (b)(6);(b)(7)(C) documented SAMIMI denied pain or nausea, although tremors were observed and he appeared anxious. Vital signs were not recorded during this encounter. He was given an injection of Ativan, administered in the right deltoid muscle.

Note: The dose of Ativan was not recorded on the MAR.

In addition to documented entries in the medical record, Dr. (b)(6);(b)(7) reported during interview that he contacted SAMIMI's named methadone clinic upon arrival at work this date. He was told SAMIMI was "not in the system." Dr. (b)(6);(b)(7) also stated he accessed the University of Colorado EpiLink database in an attempt to obtain more medical history. He said it listed visits for opioid withdrawal, "some stomach stuff," and a fall, with no recent contact. Dr. (b)(6);(b)(7) speculated SAMIMI may have used an alias to seek services.

Note: Dr. (b)(6);(b)(7)(C) contact with the clinic and accessing of the EpiLink database was not documented in the medical record, although a printout of the latter was provided to reviewers. The printout was dated nine days later, November 29, 2017 and as reported by Dr. (b)(6);(b)(7) lists multiple visits for opioid withdrawal and no recent contact. No visits related to abdominal complaints were identified.

Tuesday, November 21, 2017

Medical Unit Housing Record

SAMIMI accepted all three meals but declined recreation and a shower. Again, medical staff signed the log as did a security supervisor for each shift. All signatures are illegible.

MAR

Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen
None documented	9:00 a.m.	Given once; time not documented	None documented	Given once; time not documented

Note: Administration of as-needed medications is not addressed in nursing notes.

Vital Signs

Temperature	Pulse	Respirations	Blood Pressure	Oxygen	Weight
97.6	87	16	118/76	95	Not taken
Not taken	Not taken	Not taken	Not taken	Not taken	Not taken
Not taken	Not taken	Not taken	Not taken	Not taken	Not taken

Medical Record

Results of the laboratory tests ordered on November 17, 2017 were received and signed by Dr. (b)(6);(b)(7)(C). All tests were within normal limits with the exception of a slightly low hemoglobin level and an elevated thyroid hormone level. During interview, Dr. (b)(6);(b)(7) called the lab results "excellent" overall and cited them as a reason he was not concerned about the ability of DCDF to manage SAMIMI's withdrawal.

In the only nursing entry this date, RN (b)(6);(b)(7)(C) documented in a **6:30 p.m.** progress note that SAMIMI denied pain but appeared anxious, with tremors. Vital signs were within normal

limits (see first row of the above table). She noted he was given Ativan, administered in the right deltoid muscle. Fluids were encouraged, and the nursing plan was to continue monitoring.

Note: The dose of Ativan was not documented on the MAR.

Wednesday, November 22, 2017

Medical Unit Housing Record

SAMIMI accepted all three meals but declined recreation and a shower. Again, medical staff signed the log as did a security supervisor for each shift. All signatures are illegible with the exception of Lieutenant (b)(6);(b)(7)(C) who signed for second shift.

MAR

Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen
9:00 p.m.	9:00 a.m. 9:00 p.m.	Given twice; times not documented	Given once; time not documented	Given once; time not documented.

Note: Administration of as-needed medications is not addressed in nursing notes.

Vital Signs

Temperature	Pulse	Respirations	Blood Pressure	Oxygen	Weight
98.2	82	17	108/74	99	Not taken
Not taken	Not taken	Not taken	Not taken	Not taken	Not taken
Not taken	Not taken	Not taken	Not taken	Not taken	Not taken

Medical Record

There was only one nursing entry this date. At **6:00 p.m.**, RN (b)(6);(b)(7)(C) completed a Medical Observation Nursing Progress Record documenting SAMIMI complained of nausea and vomiting, generalized pain, tremors, and shivering related to methadone withdrawal. Vital signs were all within normal limits (see first row of above table). He reported his last caloric intake was at 5:00 p.m. at which time he ate 50 percent of his dinner. He complained of nausea after eating. The plan was to continue monitoring and administration of medication and increase fluids as tolerated.

Note: The RN did not document whether Phenergan was given for nausea, although the MAR documents a dose was administered at some point during the day.

Thursday, November 23, 2017

Medical Unit Housing Record

SAMIMI accepted all three meals but declined recreation and a shower. Again, medical staff signed the log as did a security supervisor for each shift. All signatures are illegible with the exception of Lieutenant (b)(6);(b)(7)(C) who signed for second shift.

MAR

Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen
9:00 p.m.	9:00 a.m. 9:00 p.m.	Given twice; times not documented	None documented	Given once; time not documented

Note: Administration of as-needed medications is not addressed in nursing notes.

Vital Signs

Temperature	Pulse	Respirations	Blood Pressure	Oxygen	Weight
98.1	82	16	107/74	97	Not taken
97.8	76	16	134/93	98	Not taken
Not taken	Not taken	Not taken	Not taken	Not taken	Not taken

Medical Record

At **11:15 a.m.**, RN (b)(6);(b)(7)(C) (b)(6);(b) documented SAMIMI was alert and oriented, with mild hand tremors and level four generalized pain. Vital signs were all within normal limits (see first row of above table). He was encouraged to increase his fluid intake.

Note: RN (b)(6);(b) did not document whether any medications were given.

At **1:30 p.m.**, RN (b)(6);(b) wrote in a progress note that SAMIMI complained of pain and weakness and spent most of the shift in bed. Vital signs were all within normal limits with the exception of a mildly elevated blood pressure of 134/93 (see second row of above table).

Note: RN (b)(6);(b) did not document whether any medications were given.

Friday, November 24, 2017

Medical Unit Housing Record

SAMIMI did not accept any of the three meals and declined recreation and a shower. The officer noted that the detainee did not eat breakfast due to abdominal pain and the nurse was notified.

Medical staff signed the log as did a security supervisor for each shift. Again, all signatures are illegible with the exception of Lieutenant (b)(6);(b)(7)(C) who signed for second shift.

Medical Unit Logbook

The officer made the following entries during the morning hours:

Time	Event
4:11 a.m.	SAMIMI requested ice chips; nurse approved.
5:00 a.m.	SAMIMI was having a hard time falling asleep and he was tossing and turning. A cup of ice chips were given.
6:32 a.m.	SAMIMI was screaming out for a nurse stating that he has abdominal pain. Nurses were notified.
7:45 a.m.	"Detainee SAMIMI keeps on screaming."
11:15 a.m.	The RN was in the cell with detainee SAMIMI, gave him meds and approved more ice chips.
11:59 a.m.	Captain notified detainee SAMIMI "not wanting to eat".

Note: There are no medical record entries addressing these events and response by nurses.

MAR

Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen
9:00 p.m.	9:00 a.m. 9:00 p.m.	Given twice; times not documented	Given once; time not documented	Given once; time not documented

Note: The Administration of the as-needed medications is not addressed in nursing notes. Following the fainting incident (see below), the nursing plan was to administer both Ativan and Phenergan; however, the administration of Ativan was not documented until 9:00 p.m., over six hours later, and the time Phenergan was given is not noted.

Vital Signs

Temperature	Pulse	Respirations	Blood Pressure	Oxygen	Weight
98.2	102	18	128/83	93	Not taken
98.8	77	18	129/85	96	Not taken
Not taken	Not taken	Not taken	Not taken	Not taken	Not taken

The first noteworthy incident of SAMIMI's detention period occurred during the afternoon hours this date. Officer (b)(6);(b)(7)(C) was the medical officer for the 7:00 a.m. to 3:00 p.m. shift. According her incident report, she was conducting a security round at **1:45 p.m.** when detainee SAMIMI approached the door and told her he was having abdominal pain. She told him she would notify nursing staff. As the detainee got closer to the door, he "slowly fell down." She then called for nursing staff. In the Medical Logbook, Officer (b)(6);(b)(7)(C) wrote that RN (b)(6);(b)(7)(C)

(b)(6);(b)(7)(C) Captain (b)(6);(b)(7)(C) and other responders arrived, and, “detainee being treated, unable to eat for the past 3 days, detainee looked confused, and sweaty, detainee was choking, detainee sat down by nurse to stop the choking. Detainee states that he has been flushing food can’t stand smell.” In her incident report, Officer (b)(6);(b)(7)(C) also documented SAMIMI said he had been vomiting. Captain (b)(6);(b)(7)(C) documented on the bottom of the incident report that he observed the detainee vomit into the trash can while he was sitting on his bunk and that Nurse (b)(6);(b)(7)(C) was evaluating the detainee.

Video surveillance footage of these events taken from the camera inside the cell was viewed. The video starts at **1:49 p.m.** with detainee SAMIMI laying on his bunk under a blanket. At **1:50 p.m.** he stands up and walks to the cell door. He leans on the window and appears to speak with Officer (b)(6);(b)(7)(C). He then turns to his right away from the door and slowly slides to the floor, ending up spread-eagle on his back. Subsequent events shown on the video are as follows:

Time	Event
1:50:39 p.m.	Detainee laying on his back on the floor. The feet of the officer are visible through the window moving away from the door to get assistance.
1:50:52 p.m.	The officer returns to the cell and opens the cell door.
1:51:51 p.m.	RN (b)(6);(b)(7)(C) enters the cell. He steps over the detainee, dons gloves, then kneels at the detainee’s side and appears to check his pulse. He then performs a sternal ²² rub.
1:52:27 p.m.	RN (b)(6);(b)(7)(C) tries to pull the detainee up to a sitting position. The detainee’s head can be seen lolling. The view of the detainee is now blocked by the nurse.
1:53:38 p.m.	RN (b)(6);(b)(7)(C) enters. RN (b)(6);(b)(7)(C) repositions the detainee so his back faces the wall away from his bunk. The nurse appears to check the detainee’s head.
1:54:54 p.m.	RNs (b)(6);(b)(7)(C) and (b)(6);(b)(7)(C) lift the detainee and move him to the bed. SAMIMI appears limp. He is now sitting up, with support, and RN (b)(6);(b)(7)(C) wheels in the mobile electronic vital signs monitor. RN (b)(6);(b)(7)(C) applies the cuff to the detainee’s left arm. The cuff is removed and the detainee appears to speak to RN (b)(6);(b)(7)(C). RN (b)(6);(b)(7)(C) leaves with the blood pressure machine.
1:58:04 p.m.	RN (b)(6);(b)(7)(C) returns with a pulse oximeter on the detainee’s finger.
1:58:43 p.m.	SAMIMI motions to RN (b)(6);(b)(7)(C) to bring him the wastebasket from the corner of the room. When the wastebasket was placed in front of him, detainee SAMIMI appears to vomit in it. He then places both arms on the basket for support and places his head directly over the basket. After a minute, RN (b)(6);(b)(7)(C) pulls the detainee away from the wastebasket and the detainee sits up on the bunk unassisted. After another minute the detainee is left alone in the

²² A sternal rub is the application of painful stimuli with the knuckles of a closed fist to the center chest of a patient who is not alert and does not respond to verbal stimuli. Response to the stimulus is used to make assumptions about the integrity of the brain and its function.

	cell.
2:02:55 p.m.	SAMIMI appears to vomit again in the wastebasket.
2:05:22 p.m.	SAMIMI lays down on the bed and covers himself with a blanket. The video ends.

RN (b)(6);(b)(7)(C) medical record progress note documenting this event is timed 2:30 p.m. He wrote that the medical officer alerted nursing staff that “she witnessed detainee faint in cell.” On arrival, SAMIMI was found on his back, lying on the floor, unresponsive. Attempts to rouse him verbally and physically were unsuccessful. On applying a sternal rub, SAMIMI began to regain consciousness. He was assisted to a sitting position, at which time he gave eye contact and stated he had not eaten in four days. He then lost consciousness a second time. Another nurse also attempted to perform a sternal rub, at which time SAMIMI regained consciousness. He was assisted onto the bed in a sitting position. He complained of nausea and vomiting and being unable to eat. On his request to lie down, he was assisted to the supine²³ position. His pupils were equal, round, reactive to light, and accommodative (PERRLA). Vitals signs (see first row of the above table) were within normal limits with the exception of an abnormally elevated pulse rate of 102 and an abnormally low oxygen saturation of 93 percent. The nursing assessment was dehydration and “possible drug-seeking behavior”, and the plan was to administer Ativan and Phenergan. Education was provided on diet, medications, and importance of good nutrition and fluid intake, for which he verbalized understanding.

Note: The injury assessment addressed only PERRLA and did not include assessment for other possible injuries. There is no documentation Dr. (b)(6);(b)(7)(C) was contacted for possible follow-up orders despite RN (b)(6);(b)(7)(C) assessment of dehydration and ongoing withdrawal symptoms. According to medical record documentation, a follow-up nursing assessment did not occur until six hours later.

Note: The MAR does not document administration of Ativan until 9:00 p.m. The time Phenergan was given is not documented.

Both RN (b)(6);(b)(7)(C) and RN (b)(6);(b)(7)(C) were interviewed regarding this incident. RN (b)(6);(b)(7)(C) did not recall any involvement but when shown the video, confirmed he was the second nurse. He maintained he had no recollection of the event after viewing the full video, but stated it appeared clear SAMIMI was not faking. RN (b)(6);(b)(7)(C) gave an account that stands in contrast to what he documented and what is seen on the video. He said that Officer (b)(6);(b)(7)(C) came to get him after SAMIMI supposedly fainted while she was performing a round. He said that when he got to the cell, SAMIMI started what he believed to be a feigned seizure, moving and making sounds like none he has observed in his experience. RN (b)(6);(b)(7)(C) commented that SAMIMI was not disoriented when he came out of the seizure and, looking right at him, said he had not had a seizure in ten days. Asked for other observations of detainee SAMIMI, RN (b)(6);(b)(7)(C) stated that in

²³ The supine position means lying face up.

general, detainee SAMIMI was the same on most days, resting, not saying much and not eating much. He commented that the detainee's actions got "more dramatic" as time went on; also, that "it became clear he was trying to sabotage his care." When asked for examples, RN (b)(6);(b)(7)(C) replied that SAMIMI made "grand gestures" like throwing his food down the toilet and that the detainee threw himself on the floor. The latter example refers to an incident discussed later in this report. When asked how often the detainee threw food down his toilet, RN (b)(6);(b)(7)(C) stated he knew of one time for certain.

Note: An incident report by Officer (b)(6);(b)(7)(C), summarized above, documents SAMIMI reported flushing his food because he could not tolerate the smell. Sensitivity to food aromas is common with nausea; therefore, the suggestion that SAMIMI flushed his food as a grand gesture is questionable.

Nurse (b)(6);(b)(7)(C) could not recall if he considered informing Dr. (b)(6);(b)(7)(C) that the detainee was dehydrated. He commented Dr. (b)(6);(b)(7)(C) can be difficult to reach when he is not in the office, estimating the physician does not answer two out of every five calls placed. According to RN (b)(6);(b)(7)(C) voicemail is not set up on Dr. (b)(6);(b)(7)(C) cell phone and that he returns missed calls only 50 percent of the time. Nurse (b)(6);(b)(7)(C) stated he has never been able to reach Dr. (b)(6);(b)(7)(C) on his home phone.

At **3:12 p.m.**, Officer (b)(6);(b)(7)(C) noted in the Medical Logbook that detainee SAMIMI "is doing much better."

At **8:30 p.m.** RN (b)(6);(b)(7)(C) completed a Medical Observation Nursing Progress Record. He wrote that SAMIMI complained of nausea and vomiting "unobserved by staff." Vital signs (see second row of the above table) were all within normal limits, with the exception of a slightly elevated temperature of 98.8 signifying a slight fever. SAMIMI's last bowel movement was the previous day, and his dinner intake at 5:00 p.m. was 50 percent. The assessment findings included, "Signs and symptoms of withdrawal, no tremors, no seizures". The nursing plan was to continue monitoring and encourage food and nutritional intake.

Note: November 24, 2017 was the seventh day of detainee SAMIMI's housing in medical. There is no renewal of housing orders for continuation of this status as required by GEO policy 905-A, Medical Observation.

Saturday, November 25, 2017

Medical Unit Housing Record

SAMIMI refused all three meals and declined recreation and a shower. Again, medical staff signed the log as did a security supervisor for each shift. All signatures are illegible with the exception of Lieutenant (b)(6);(b)(7)(C) who signed for both first and second shift.

Medical Unit Logbook

Time	Event
1:35 p.m.	SAMIMI missed his third meal.
4:00 p.m.	A nurse took SAMIMI's vital signs.
7:20 p.m.	SAMIMI refused supper after repeated offers. The tray was thrown out at his request.

MAR

Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen
None documented	9:00 a.m. 9:00 p.m.	Given twice; times not documented	None documented	Given once; time not documented

Note: The basis for administration of as-needed medications is not addressed in nursing notes. In her 6:30 p.m. progress note, RN (b)(6);(b)(7)(C) documented she gave Phenergan not recorded on the MAR.

Vital Signs

Temperature	Pulse	Respirations	Blood Pressure	Oxygen	Weight
97.8	76	16	134/93	98	Not taken
Not taken	91	16	127/93	96	Not taken
Not taken	Not taken	Not taken	117/88	Not taken	Not taken

Medical Record

RN (b)(6);(b)(7)(C) completed a Medical Observation Nursing Progress Record, again failing to document the time. He wrote that SAMIMI complained of abdominal pain at a level six, with weakness, nausea, and vomiting. Vital signs (see first row of the above chart) were all within normal limits, with the exception of a mildly elevated blood pressure. Assessment of SAMIMI's heart, lungs, and abdomen were normal, and he reported having his last bowel movement the previous day. It was noted he ate 30 percent of his lunch at 11:30 a.m. and consumed water at 12:30 p.m.

Note: RN (b)(6);(b)(7)(C) did not document whether he gave any medications.

At **6:30 p.m.**, RN (b)(6);(b)(7)(C) documented in a progress note that SAMIMI was lying in bed and reported he did not sleep the previous night. Vital signs (see second row of the above table) were all within normal limits with the exception of a slightly elevated blood pressure. The same vital signs were recorded on a CIWA completed by RN (b)(6);(b)(7)(C) during the same encounter. The flow sheet score was 17 based on nausea/vomiting, tremors, anxiety, and paroxysmal sweating, although the reviewer determined the scores were incorrectly added. The correct total was 13 which according to the form, indicates moderate alcohol withdrawal.

Note: Although the CIWA was not the proper monitoring instrument and the score of 17 tabulated by RN (b)(6);(b)(7)(C) was incorrect, the score she determined exceeds the threshold of 15 identified on the form as indicative of severe alcohol withdrawal. Although the form does not dictate provider notification, and there were no orders so requiring, prudent nursing practice called for contacting Dr. (b)(6);(b)(7)(C).

In her note, RN (b)(6);(b)(7)(C) documented she gave Phenergan for complaint of nausea, and instructed SAMIMI to pick up his trash, clean his room, and to stay up as much as possible during the day.

Note: RN (b)(6);(b)(7)(C) did not document administration of Phenergan on the MAR.

Sunday, November 26, 2017

Medical Unit Housing Record

SAMIMI refused all three meals and he declined recreation and a shower. Medical staff signed the log as did a security supervisor for each shift. All signatures are illegible.

Medical Unit Logbook

Time	Event
2:03 p.m.	SAMIMI was eating "small portions of food like oranges, cookies, a little bit of milk & water."
3:00 p.m.	Officer (b)(6);(b)(7)(C) was told by the off-going shift to keep an eye on detainee SAMIMI "as he has not been eating".
5:10 p.m.	SAMIMI refused his dinner and requested that the tray be removed from his cell. Ice chips were provided to him per his request.

MAR

Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen
None documented	9:00 a.m.	Given once; time not documented	None documented	Given once; time not documented

Note: Administration of cyclobenzaprine and ibuprofen was not addressed in nursing notes. Although referenced in a 6:40 p.m. nursing note, administration of Phenergan was not documented on the MAR.

Vital Signs

Temperature	Pulse	Respirations	Blood Pressure	Oxygen	Weight
98	111	16	107/81	99	Not taken
97.6	71	16	125/85	96-97	Not taken
Not taken	92	16	126/78	96	Not taken

Medical Record

RN (b)(6);(b)(7)(C) completed a Medical Observation Nursing Progress Record at **12:00 p.m.** She documented that SAMIMI complained of having pain all over but did not document a pain level. SAMIMI was alert and oriented, his lung sounds were clear, and heart and abdomen assessments were normal. Vital signs (see first row of the above table) were within normal limits with the exception of an abnormally elevated pulse rate.

RN (b)(6);(b)(7)(C) wrote that vomiting was not observed. SAMIMI's speech was slurred and he was "unsteady until encouraged to walk, then walked good." He did not recall his last bowel movement and was uncertain of the last time he ate. RN (b)(6);(b)(7)(C) noted his accounts varied. The nursing assessment was "possible withdrawal", and the plan was to continue with the plan of care and monitor his food intake.

Note: RN (b)(6);(b)(7)(C) did not document whether medication was given.

The second medical record entry was timed **6:40 p.m.** when RN (b)(6);(b)(7)(C) completed a CIWA. SAMIMI's vital signs (see second row of the above table) were all within normal limits. The total score as tabulated by RN (b)(6);(b)(7)(C) was 19 based on the detainee's level of anxiety, nausea and vomiting, tremors, and paroxysmal sweats. When scores applied were re-tabulated, the reviewer discovered that for the third time, the RN made an addition error. The correct score was 16. As noted above, the threshold for severe alcohol withdrawal is 15.

Note: Again, although assessment instruments for alcohol and opiate withdrawal differ, both factor the symptoms identified by RN (b)(6);(b)(7)(C) as continuing and increasing. As before, RN (b)(6);(b)(7)(C) did not notify Dr. (b)(6);(b)(7)(C).

An accompanying progress note by RN (b)(6);(b)(7)(C) also timed 6:40 p.m., documents SAMIMI's complaints of feeling very weak, nauseated, and unable to eat. She noted that he "raised up on knees and fell over to buttocks", adding, "He did this because he is so weak." RN (b)(6);(b)(7)(C) wrote that the officer reported SAMIMI had not eaten lunch or dinner, and that she told him that because he was so weak, he would only receive Phenergan. She also told him that following medication pass, she would assess how he was feeling. Vital signs documented on CIWA were repeated in the note. RN (b)(6);(b)(7)(C) instructed the medical officer to take him to the TV room with food and water.

In a subsequent note timed **8:45 p.m.**, RN (b)(6);(b)(7)(C) wrote that the medical officer reported that SAMIMI was in the TV room for 40 minutes and then knocked on the window, urgently requesting to use the bathroom. She wrote that on exiting he "ran from TV room to 539. Appears to have less weakness." RN (b)(6);(b)(7)(C) documented that she explained that he would have to eat before taking medications. SAMIMI consumed a half cookie and half an orange, after which the remainder of medication was administered. The nursing plan was to give over-

the-counter Pepto-Bismol²⁴ 30 mg at night for three days and to continue to monitor in medical observation.

Note: The room number documented by RN (b)(6);(b)(7)(C) 539, is incorrect. SAMIMI's cell was 537.

Note: RN (b)(6);(b)(7)(C) does not specify the remaining medications referenced in her note.

Officer (b)(6);(b)(7)(C) summarized this incident in an untimed entry to the Medical Unit Housing Record. She wrote that SAMIMI refused dinner but asked for ice. In an addendum, she wrote he was, "complaining he is very sick to his stomach. Refused to eat dinner and asked that I remove it, along w/ his lunch, from his room as the smell was bothering him. Agreed to go to the TV room for 40 mins. Left due to upset stomach and needing to use the restroom. Have observed him eat a few pieces of orange and drink milk. Back to TV room at 9:10 p.m."

(b)(6);(b)(7)(C) As she documented, Officer (b)(6);(b)(7)(C) recalled on interview that SAMIMI did not want to eat and asked that trays be removed from his cell as the smell of the food was making him ill. She asked him if he wanted to shower, suggesting it might make him feel better, but he declined. According to Officer (b)(6);(b)(7)(C), she convinced SAMIMI to go to the television room because RN (b)(6);(b)(7)(C) told him she would not give him Ativan until he got up and moved around. He was able to get up and sit in the wheelchair and was wheeled to the television room. Officer (b)(6);(b)(7)(C) said that while he was there, she cleaned his cell and got clean bed linens so the detainee would feel a little better when he returned. When she went to check on him, he was frantically knocking on the window and said he needed to use the bathroom. She let him out of the room and he did a "fast walk" back to his cell. She stated RN (b)(6);(b)(7)(C) asked her to document that he moved quickly and without difficulty. She recalled the RN shared that Dr. (b)(6);(b)(7)(C) was thinking about discharging SAMIMI from the medical unit and to avoid going to general population, the detainee was faking. Officer (b)(6);(b)(7)(C) said this was not the first occasion medical staff voiced their opinion that SAMIMI was faking his symptoms. In the opinion of the officer, he was not faking and he did, in fact, look worse than when she conducted his intake.

According to Officer (b)(6);(b)(7)(C), SAMIMI asked to rest for a while after he returned to his cell. After RN (b)(6);(b)(7)(C) gave him a medication, SAMIMI wanted to return to the TV room and was taken by wheelchair. Video surveillance footage from the camera inside the TV room shows the following:

²⁴ Pepto-Bismol is an over-the-counter medication for loose stools.

Time	Event
9:28 p.m.	SAMIMI is seated in a wheelchair at the rear of the room with his back to the camera. His feet, in socks, are up on the table in front of him.
9:30 p.m.	SAMIMI removes his feet from the table and slowly slides from the wheelchair onto the floor. He then covers himself with a blanket. <i>Note: The move to the floor appears purposeful and because it was very slow, does not appear to be a fall.</i>
9:34 p.m.	Officer (b)(6);(b)(7)(C) enters the room and turns on the light on. She speaks with the detainee, he sits up, then stands and returns to the wheelchair. He puts both of his feet on the table as the officer leaves, turning the light off.
9:35 p.m.	Detainee SAMIMI moves his feet from the table to a chair in front of him. The video ends.

RN (b)(6);(b)(7)(C) documented in a 9:00 p.m. progress note that the officer reported SAMIMI slid out of his wheelchair while in the television room, but he was able to get back into the chair by himself. No injury was noted, and he returned to his cell “to relax”. Vital signs (see third row of above table) were within normal limits.

Monday, November 27, 2017

Medical Unit Housing Record

SAMIMI did not wake up to eat breakfast, did not eat lunch or dinner and declined recreation and a shower. No medical staff signed the log. A security supervisor signed for each shift although the signatures are illegible. A notation for first shift documented, “Did not eat lunch only ate ice.” A notation for third shift noted, “Did NOT eat.”

Medical Unit Logbook

Time	Event
11:05 a.m.	SAMIMI did not eat breakfast and when provided his lunch tray stated he only wanted ice. He was given two cups of ice.
5:30 p.m.	SAMIMI still had not eaten his dinner.
6:59 p.m.	“Samimi informed me that hes [sic] on a hunger strike – wants ice Nurse said no ice”.
8:41 p.m.	“Samimi finally got up for water”
8:54 p.m.	Nurse in the cell giving SAMIMI medication and water.

Note: GEO Policy 614, Hunger Strikes, states, “Detainees declaring and/or identified as being on a Hunger Strike (missed 9 consecutive meals) will be monitored daily.” Despite the detainee declaring he was on a hunger strike, there was no clear documentation medical was notified or that daily monitoring was initiated. The requirement to initiate monitoring upon declaration of a hunger strike exceeds the PBNDS 2011, Hunger Strike,

2016 revision. The standard states detainees who have not eaten for 72 hours are to be considered on hunger strike. The PBNDS definition of hunger strike was not met during SAMIMI's detention.

MAR

Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen
None documented	9:00 p.m.	Given once; time not documented	None documented	Given once; time not documented

Note: Although not documented on the MAR, RN (b)(6);(b)(7)(C) documented in a 1:00 a.m. nursing note that she gave an injection of Ativan.

Note: Administration of clonidine, cyclobenzaprine and ibuprofen was the first in 36 hours.

Vital Signs

Temperature	Pulse	Respirations	Blood Pressure	Oxygen	Weight
Not taken	98	12	124/80	95	Not taken
Not taken	Not taken	Not taken	Not taken	Not taken	Not taken
Not taken	Not taken	Not taken	Not taken	Not taken	Not taken

Medical Record

A **1:00 a.m.** progress note by RN (b)(6);(b)(7)(C) documents SAMIMI was yelling for the nurse because he was unable to relax. She wrote that Ativan was administered intramuscularly to right coccyx²⁵. During interview, RN (b)(6);(b)(7)(C) acknowledged reference to the coccyx was incorrect. The injection was administered to the gluteal muscle.

Note: Administration of Ativan was not recorded in the MAR.

Note: The next nursing assessment was conducted more than 17 hours later.

LPN (b)(6);(b)(7)(C) completed a progress note at **7:00 p.m.** documenting SAMIMI refused to eat dinner and requested stronger medications. Recorded vital signs (see first row of the above chart) were within normal limits. He was encouraged to eat and drink.

²⁵ The coccyx is the final segment of the vertebral column, also known as the tail bone.

Tuesday, November 28, 2017

Medical Unit Housing Record

SAMIMI accepted breakfast and lunch trays and refused dinner, recreation, and shower. No medical staff signed the log. An unknown security supervisor signed for first shift and noted, "Did NOT eat". Lieutenant (b)(6);(b)(7)(C) signed for second shift. No security supervisor signed off on third shift.

MAR

Ativan	Clonidine	Cyclobenzaprine	Phenergan	Ibuprofen
None documented	9:00 a.m.	Given once; time not documented	Given once; time not documented	Given once; time not documented

Note: Administration of the as-needed medications was not addressed in the nursing notes.

Vital Signs

Temperature	Pulse	Respirations	Blood Pressure	Oxygen	Weight
98.1	107	18	124/91	95	Not taken
97.7	120	16	108/82	100	Not taken
Not taken	Not taken	Not taken	Not taken	Not taken	Not taken

There were two noteworthy events this date. Shortly after 11:00 a.m., SAMIMI collapsed in the hallway on his way to a follow up mental health appointment with Dr. (b)(6);(b)(7) Video from the surveillance camera covering the medical unit corridor shows the following:

Time	Event
11:13 a.m.	A pill cart is seen at the door. As the door opens, SAMIMI and an officer are seen moving in the direction of the cart. The pill cart blocks the view, but as it is moved aside, SAMIMI is seen lying face down on the floor just inside the door.
11:14 a.m.	The nurse who was with the pill cart walks down the corridor toward the camera, leaving the detainee laying on the floor. The nurse returns with a mobile vital signs monitor and leans down to assist the detainee.
11:15 a.m.	RN (b)(6);(b) walks down the corridor and leans down to check on the detainee.
11:16 a.m.	RN (b)(6);(b) pulls the detainee up to a standing position. SAMIMI's knees appeared to buckle but he remains upright.
11:17 a.m.	SAMIMI, with an unidentified nurse holding his right arm and RN (b)(6);(b) on his left, walk down the corridor toward the camera. They are met in the hallway by Dr. (b)(6);(b)(7) who appears to speak with SAMIMI. The nurses and the detainee then turn around and head back toward the door while Dr. (b)(6);(b)(7) goes to Dr. (b)(6);(b)(7)(C) office. SAMIMI then leaves with the unidentified nurse.

The medical record progress note documenting this incident was entered by RN (b)(6);(b) at **11:50 a.m.** RN (b)(6);(b) wrote that no injuries were noted. SAMIMI reported not having eaten in eight days due to nausea and requested stronger medications to combat his withdrawal symptoms. Vital signs (see first line of above table) were within normal limits with the exception of an abnormally elevated pulse rate and very slightly elevated blood pressure.

Note: An elevated pulse rate is a common sign of dehydration. RN (b)(6);(b) did not document skin turgor testing²⁶ to assess loss of fluid in the body.

SAMIMI denied pain. The nursing assessment was “Dehydration, nutritional needs not met.” The plan was to continue to monitor and administer medications as ordered, and the detainee was educated on the need to make an effort to eat and drink. RN (b)(6);(b) wrote, “no matter his actions, stronger meds unavailable.” Questioned about this statement, RN (b)(6);(b) explained he was trying to make the point to the detainee that he was not helping himself by doing the things he was doing and that he needed to cooperate because he was not going to get methadone.

Note: In spite of the nursing assessment of dehydration, likely worsening due to vomiting, sweating, and inadequate fluid intake, Dr. (b)(6);(b)(7) was not informed. Given the totality of the circumstances, notification of a provider would have been proper nursing practice.

In a progress note timed **11:16 a.m.**, Dr. (b)(6);(b)(7) documented SAMIMI collapsed when leaving his cell in medical and was observed lying in the hallway with two nurses rendering care. She described him as pasty in appearance, confused, wobbly, and disheveled. In discussing the matter with Dr. (b)(6);(b)(7)(C) they agreed that the detainee was not stable enough to proceed with his mental health follow up appointment. According to Dr. (b)(6);(b)(7)(C) note, Dr. (b)(6);(b)(7) said medical was monitoring his vital signs and stated “He had a few good days. Other than some thyroid that we will need to supplement, his labs look good.” The plan was to keep SAMIMI in medical observation as he undergoes withdrawal. When stable enough to have a coherent conversation with ability to engage and to understand and comprehend the content, he would return to the mental health clinic. During interview, Dr. (b)(6);(b)(7) confirmed the information and observations in her note, adding that it was clear SAMIMI was “really ill.” Contrary to what is shown in the video, she also stated she did not approach after witnessing the detainee lying in the hallway.

According to the Visitor Log, detainee SAMIMI had a one hour visit with (b)(6);(b)(7)(C) at **5:12 p.m.** The relationship is not noted on the log.

²⁶ Skin turgor testing involves grasping the skin on the lower forearm between two fingers. The skin is held for a few seconds then released. Skin with normal turgor snaps rapidly back to its normal position.

The second noteworthy incident of the day was SAMIMI's suicide attempt at approximately **8:45 p.m.** According to her incident report, Officer (b)(6);(b)(7)(C) went into the anteroom of cell 537 to perform a security round. When she looked through the window, she observed SAMIMI with a dark blue sheet tied around his neck. On interview, Officer (b)(6);(b)(7)(C) stated she reached for her radio on her duty belt so she could call an emergency. Discovering the radio was dead, she hurried to the officer's station and used the telephone to call central control for assistance. She returned to the cell, alerting nursing staff along the way that there was an emergency. Once other staff were present, Officer (b)(6);(b)(7)(C) opened the cell door and responding medical and officer staff forcibly removed the sheet from around the detainee's neck. Officer (b)(6);(b)(7)(C) stated she heard someone say SAMIMI would be placed on suicide watch so she left to make preparations. Her preparations included setting up the officer's table and constant watch logbook outside the suicide prevention cell, and retrieving a suicide resistant smock and blanket for issuance to the detainee.

Lieutenant (b)(6);(b)(7)(C) responded to the emergency call and noted in a Supervisor Supplemental Report that Officer (b)(6);(b)(7)(C) reported she witnessed the detainee with a shirt around his head and his arms wrapped around the neck. He also noted that first responders were already in the cell and the shirt was taken off his head. Lieutenant (b)(6);(b)(7)(C) documented Dr. (b)(6);(b)(7)(C) placed the detainee on constant suicide watch which was "started immediately."

Note: As indicated below, reviewers confirmed SAMIMI used a sheet, not a shirt, in the suicide attempt.

Video from the camera in SAMIMI's cell and the camera in the medical unit hallway was reviewed to determine the timing of events. The camera in the hallway shows the officer's station on the left, the enclosed nurses' station on the right, and cell 537 directly ahead at the end of the hallway. The following events are shown:

Time	Event	Camera
8:42:50 p.m.	SAMIMI sits up in bed with his back against the wall.	Cell
8:44:52 p.m.	Officer (b)(6);(b)(7)(C) takes the electronic pipe and keys and leaves the officer's station to conduct a round. When she reaches the end of the corridor, she turns right out of the camera's view.	Hall
8:44:58 p.m.	SAMIMI takes the blue sheet from his bed and places it around his neck from behind. He then crosses each end over the other and tightens the sheet by pulling with each arm. <i>Note: It not possible to gauge the amount of tension placed on the sheet and how much it tightened around the detainee's neck.</i> The detainee remained seated on the bunk as he tightened the sheet.	Cell
8:46:16 p.m.	Officer (b)(6);(b)(7)(C) re-enters the camera's view at the end of the hallway and enters the outer door into the anteroom outside SAMIMI's cell.	Hall

(b)(6);(b)(7)(C)	8:46:33 p.m.	Officer (b)(6);(b)(7)(C) exits the outer door and is back in the corridor. She walks to the nurses station (enclosed) approximately ten feet away and motions to the nurse to come to the door. The nurse opens the door at 8:46:54 p.m.	Hall
	8:47:25 p.m.	Officer (b)(6);(b)(7)(C) walks back to the officer's station, approximately 10 feet from the nurses station, holding her radio in her left hand. She looks at the monitor on her desk displaying camera views of the cells.	Hall
	8:47:25 p.m.	Officer (b)(6);(b)(7)(C) picks up the phone.	Hall
	8:48:14 p.m.	Officer (b)(6);(b)(7)(C) hangs up the phone, returns to SAMIMI's cell and opens the outer door at 8:48:32.	Hall
	8:48:40 p.m.	The light in the cell is turned on.	Cell
	8:49:12 p.m.	Nurse (b)(6);(b)(7)(C) and an unidentified officer enter the cell, donning gloves. RN (b)(6);(b)(7)(C) and Officer (b)(6);(b)(7)(C) enter behind them. Nurse (b)(6);(b)(7)(C) and the first officer remove the sheet from around SAMIMI's neck as he struggles briefly and tries to push them away. Several more officers arrive. SAMIMI speaks with staff as his property and linens were removed from the cell. The detainee is seated on the bed, cross-legged, and leans forward with his hands on his forehead.	Cell
	8:50:46 p.m.	Lieutenant (b)(6);(b)(7)(C) enters the cell, looks at the detainee's ID badge and leaves.	Cell
	8:51:18 p.m.	RN (b)(6);(b)(7)(C) picks up the Styrofoam meal container and looks inside. It appears to contain a full meal.	Cell
	8:51:25 p.m.	The property bin is removed. RN (b)(6);(b)(7)(C) opens the meal container and shows it to the detainee.	Cell
	8:51:41 p.m.	SAMIMI shakes his head no, and RN (b)(6);(b)(7)(C) sets the container on the floor at the end of the bed. The RN departs, leaving the detainee alone with the cell door left open. The detainee remains seated cross-legged on the bed, leaning forward with his hands on his forehead.	Cell
(b)(6);(b)(7)(C)	8:52:17 p.m.	An officer enters and removes the wastebasket.	Cell
	8:52:39 p.m.	SAMIMI appears to say something to someone outside the cell.	Cell
	8:55:08 p.m.	SAMIMI removes his hands from his head and sits upright.	Cell
	8:55:29 p.m.	Lieutenant (b)(6);(b)(7)(C) re-enters the cell. For the next three minutes, SAMIMI speaks to the Lieutenant in an animated way, gesturing with his arms and hands, pointing at his head and throwing his arms wide open.	Cell
	8:58:28 p.m.	Lieutenant (b)(6);(b)(7)(C) leaves the cell.	Cell
	8:59:14 p.m.	SAMIMI looks toward the cell window.	Cell
	8:59:55 p.m.	SAMIMI lays down on his bed on his left side with his arms covering his face.	Cell

9:01:49 p.m.	An officer enters the cell, squats down at the head of the bed and speaks to the detainee.	Cell
9:02:30 p.m.	SAMIMI swings his legs over the side of the bed onto the floor and sits up. The officer then assists him to his feet and they walk out of the cell with the officer holding the detainee's left arm.	Cell
9:03:08 p.m.	Officer [redacted] re-enters the cell and places the property bin back into the empty cell. She then removes what appeared to be a pillow case or cloth from behind the bed.	Cell

Note: More than two minutes elapsed between the time Officer [redacted] appears to have first observed SAMIMI with the sheet around this neck and when she returned to the cell.

The medical record entry documenting this incident was entered at 8:45 p.m. by RN [redacted]. He wrote that the medical officer called, "All response team to medical." Responding nurses found SAMIMI sitting on his bed, "legs closed with a tight bed sheet around his neck and pulling strong on both ends of the sheet with his arms." He noted that the response team "forcefully removed the bed sheet around his neck." SAMIMI was described as alert, disheveled, and able to make needs known. He stated, "I haven't slept in 14 days. I want medication to help me sleep." A call was made to Dr. [redacted] notifying him of the incident, and the following verbal orders were obtained:

1. Suicide Level one with one-on-one monitoring;
2. Suicide gown, suicide blanket, suicide pillow;
3. Finger foods with paper spork;
4. Ten sheets of toilet paper at a time;
5. One small book or Bible;
6. No underwear, no bed sheet;
7. Mental health appointment.

RN [redacted] documented the orders in his nursing note and in the Special Instructions section of the Suicide Alert – Level 1 form.

Note: Dr. [redacted] did not document authentication of his verbal orders.

The Medical Unit Logbook documents the detainee was placed on constant suicide watch in cell 527 at **8:53 p.m.**

Note: The GEO track system erroneously documents the date and time of placement as November 29, 2017 at 9:33 a.m.

Cell 527 is the designated suicide watch cell. The door has a window in the top half and a pipe sensor in the middle. To the right of the door is a large viewing window. Bolted to the center of

the floor inside the cell is a concrete bed slab. A stainless steel toilet and sink combination fixture is in the back left corner of the cell. A camera is mounted at the back of the cell near the ceiling and shows a view of the bed, toilet and cell door and window. Per Security Chief (b)(6);(b)(7)(C) this camera is motion-activated and only records when there is movement.

As noted, SAMIMI was placed on Level one suicide watch with constant, one-on-one monitoring. The desk for the officer assigned to constant watch is positioned immediately outside the large viewing window and can be seen from the camera inside the cell. The officer is required to log the activity of the detainee every five minutes in the Constant Watch Logbook (separate from the Medical Unit Logbook) and is not allowed to leave the post without being properly relieved. Per the ICE PBNDS, 2016 revision, detainees placed on suicide watch are to receive eight-hour checks by clinical staff and daily mental health treatment by a qualified clinician.

Note: There were no medical record entries documenting any encounters with a health care professional between the time SAMIMI was placed on suicide watch and 11:00 a.m. the next morning. As discussed below, nurse/clinician welfare checks were not conducted every eight hours as required by the ICE PBNDS.

Entries to the Constant Watch Logbook for this date documented SAMIMI mainly slept or laid down on the bed. He complained twice of being too cold.

Wednesday, November 29, 2017

Medical Unit Housing Record

SAMIMI accepted a breakfast tray but there are no notations regarding lunch or dinner or whether he refused or accepted a shower or recreation. Medical staff signed the log as did a security supervisor for each shift. All signatures are illegible.

Medical Unit Logbook

At **12:15 a.m.** nurses were notified that detainee SAMIMI had blood on his arm.

Note: The officer assigned to the constant watch did not document this information in the Constant Watch Logbook.

Note: There were no corresponding documentation in the medical record.

At **10:58 a.m.** ERO officer (b)(6);(b)(7)(C) initialed the Medical Unit Logbook documenting she was present for "Staff/detainee communication."

Constant Watch Logbook

Entries from midnight until 10:55 a.m. primarily documented SAMIMI was sleeping or laying on his bed. Other entries were as follows:

Time	Event
1:40 a.m. to 2:20 a.m.	SAMIMI intermittently “banging on his bunk”.
2:30 a.m.	Detainee asked to speak to a nurse.
2:35 a.m.	Detainee seen by a nurse
4:45 a.m.	Breakfast served; detainee ate.
6:50 a.m.	Detainee stated he was cold and wanted clothes.
8:10 a.m.	Detainee spoke with Nurse (b)(6);(b) and was given antacids.
9:55 a.m.	Nurse was notified the detainee was sweating.
10:05 a.m.	Detainee was yelling.
10:55 a.m. to 11:00 a.m.	Detainee met with the tele-psychiatrist, returning to cell at 11:05 a.m.

MAR (Reflects medication changes following 11:00 a.m. tele-psychiatry encounter)

Clonidine	Hydroxyzine	Immodium	Trazodone	Cyclo-benzaprine	Phenergan	Ibuprofen
9:00 p.m.	None documented	None documented	None documented	None documented	Given once; time not documented	None documented

Note: Administration of as-needed Phenergan was not addressed in a nursing note.

Vital Signs

Temperature	Pulse	Respirations	Blood Pressure	Oxygen	Weight
97.7	120	16	108/82	100	Not taken
Not taken	Not taken	Not taken	Not taken	Not taken	Not taken
Not taken	Not taken	Not taken	Not taken	Not taken	Not taken

Medical Record

At **11:00 a.m.**, an initial psychiatric evaluation was completed via tele-psychiatry with Dr. (b)(6);(b)(7)(C) MD.

Note: This was 14 hours after the suicide attempt, with no nursing rounds in between.

The subjective section noted, “He clearly stated after emergency team responded that what he would like was medication for sleep.”

Note: In the subjective section or elsewhere, there is no documentation SAMIMI was asked why he attempted suicide.

Dr. (b)(6);(b)(7)(C) documented detainee SAMIMI complained of inability to sleep, constant vomiting, sweating, and shaking. He denied other opiate symptoms of yawning, tears, and diarrhea. He also denied suicidal intent. Regarding the CIWA scores, Dr. (b)(6);(b)(7)(C) documented, "CIWA score consistently increasing over time. Patient has been noted to have tremors and to be requesting 'stronger medication' frequently." Detainee SAMIMI Dr. (b)(6);(b)(7)(C) note listed what to expect with opiate withdrawal, stating, "It is generally not life threatening, although dehydration can occur," and she addressed the unsuitability of using the CIWA instead of an opiate withdrawal instrument. Findings included orientation to person, place, time, and situation; appropriateness of rapport; disheveled appearance with poor grooming, dress, and body odor; anxious, irritable mood; expansive affect; and coherent, appropriate speech.

Note: Dr. (b)(6);(b)(7)(C) description of the detainee's body odor is assumed to have been reported to her by RN (b)(6);(b)(7)(C)

The plan included:

- Push fluids for 15 days;
- Discontinue Ativan;
- Clonidine 0.1 mg orally three times daily for four days, then clonidine 0.1 mg twice daily for four days, then 0.1 mg every night for four days, then stop;
- Hydroxyzine²⁷ 50 mg three times daily as needed for anxiety for 15 days.
- Immodium²⁸ 2 mg after each loose stool, total daily dose not to exceed 16 mg as needed for three days;
- Trazodone²⁹ 100 mg orally every night as needed for sleep for 15 days, then decrease to 50 mg every night for 15 days, then stop;
- Offer Ensure with each meal for seven days;
- COWS monitoring for ten days;
- Level 2 suicide watch.

The Special Instructions form for Suicide Alert – Level 2, signed by Dr. (b)(6);(b)(7)(C) at 2:15 p.m., authorizes, "May have toilet paper. May have shower, soap and comb, toothbrush, underwear OK. May have regular diet and spork. May have reading material. May have GEO uniform. Suicide mattress and pillow."

Dr. (b)(6);(b)(7)(C) documented she discussed symptoms and treatment of mental illness and frequency of follow-up, prescribed medications and potential side effects, and explanation of access to mental health services. She also documented medication consent forms were reviewed and signed.

²⁷ Hydroxyzine is a medication used to treat anxiety, nausea and vomiting.

²⁸ Immodium is a medication to treat loose stools or diarrhea.

²⁹ Trazodone is a medication used to treat anxiety, depression, and sleeplessness.

Dr. (b)(6);(b)(7)(C) orders were noted by RN John (b)(6);(b)(7)(C) the same day, and the medications were accurately transferred to the MAR. Consent for Mental Health Services and Consent for psychiatric medication hydroxyzine were signed by detainee.

Note: Consent for use of psychiatric medication Trazodone was not included in the medical record.

Note: Although the order for Ensure was noted on the MAR, there is no documentation it was offered with every meal as prescribed.

Note: Subsequent nursing documentation does not include inquiry into recurrent loose stools.

A blank COWS form was found in the medical record. During interview of RN (b)(6);(b)(7)(C) he stated Dr. (b)(6);(b)(7)(C) mentioned she was surprised no COWS assessments had been completed. He added that he had to research the instrument and printed the form from the internet following the encounter with Dr. (b)(6);(b)(7)(C).

Note: No COWS was ever completed after ordered by Dr. (b)(6);(b)(7)(C).

At **11:20 a.m.** RN (b)(6);(b)(7)(C) documented a Medical Observation Nursing Progress Record, at which time SAMIMI complained of nausea. His vital signs (see first row of the above table) were all within normal limits with the exception of the abnormally elevated heart rate.

Note: There is no indication this finding was reported to the provider, nor does the MAR show that anti-nausea medication was administered.

An entry in the Medical Housing Unit Log timed **2:18 p.m.** documents SAMIMI was moved to Level Two suicide watch. At this point, monitoring checks and notations in the Constant Watch Logbook were required every 15 minutes. Except for the following, entries to the logbook following the tele-psychiatry evaluation on this date primarily documented SAMIMI slept or laid in his bed.

Time	Event
5:01 p.m.	Dinner was served; detainee "ate just a little bit" but was eating and drinking again at 5:24 p.m.
7:45 p.m.	Detainee provided with a uniform "approved on special instructions for detainee."
10:15 p.m.	Detainee requested ice water
10:30 p.m.	Detainee again requested ice water. Per Nurse Ross he should "get it from the sink" in his cell.
11:00 p.m.	Detainee continued to request ice water.

Note: As noted above, the special instructions form stating SAMIMI was to be allowed a uniform and setting other conditions for level 2 suicide watch was signed by Dr. (b)(6);(b)(7)(C) at 2:15 p.m. The five hour, 30 minute delay is unexplained.

Thursday, November 30, 2017

Medical Unit Housing Record

SAMIMI did not accept any meals and did not shower or go to recreation. Again, medical staff signed the log, as did a security supervisor for first and third shift. No security supervisor signed for second shift. All signatures are illegible.

MAR

Clonidine	Hydroxyzine	Immodium	Trazodone	Cyclo-benzaprine	Phenergan	Ibuprofen
9:00 a.m. 3:00 p.m. 9:00 p.m.	9:00 a.m. 3:00 p.m. 9:00 p.m.	None documented	9:00 p.m.	Given once; time not documented	None documented	Given twice; times not documented

Note: Administration of as-needed Phenergan and Trazodone were not addressed in a nursing note.

Vital Signs

Temperature	Pulse	Respirations	Blood Pressure	Oxygen	Weight
97.6	88	16	100/70	95	Not taken
97.8	100	15	101/70	97.8	Not taken
Not taken	Not taken	Not taken	Not taken	Not taken	Not taken

The Constant Watch Logbook noted the detainee had a nose bleed at **12:30 a.m.** and the officers and nurses cleaned the detainee and the cell. In a **2:00 a.m.** progress note, RN (b)(6);(b)(7)(C) documented "Detainee on suicide level two. Resting off and on. Screams, 'Nurse, nurse,' then he is asleep." Vital signs (see the top row of the above table) were all within normal limits. RN (b)(6);(b)(7)(C) wrote that at 1:00 a.m. he was observed to have blood on his nose, the sleeve of his right arm, and in his mouth, which he spit onto the floor. Following a full nursing assessment, RN (b)(6);(b)(7)(C) noted the blood appeared to be coming from his nose, although during interview, she stated she could not recall how she reached the conclusion that he was bleeding from his nose as opposed to his mouth. After he was cleaned up and provided new clothes, vital signs were repeated and were within normal limits (see second row of above chart). The nursing plan included offering water every two hours while awake, continue to monitor, and notify the morning staff.

Note: RN (b)(6);(b)(7)(C) did not notify Dr. (b)(6);(b)(7) SAMIMI was bleeding through his nose for no apparent reason, which was significant given his compromised condition.

The Constant Watch Logbook documents SAMIMI was screaming from **4:30 a.m. to 5:15 a.m.** He screamed off and on until **6:57 a.m.** when the officer documented an unnamed nurse denied ice water again and stated the detainee “will drink water like everyone.” At **7:08 a.m.** it was logged the detainee refused to eat.

Security shift change occurred at **7:10 a.m.** The oncoming officer logged receipt of pass-down information that SAMIMI was not eating. He drank fluids at **8:45 a.m.** and refused the nurse’s request to take his vital signs at **9:22 a.m.** A medical record progress note by RN (b)(6);(b)(7)(C) corroborates this information. At **9:25 a.m.**, she documented SAMIMI’s refusal to get up for his nursing assessment, describing him as “irate.” When asked about his specific behavior during interview, RN (b)(6);(b)(7)(C) stated only that he called her names.

At **11:57 a.m.** the log documents a nurse took SAMIMI to the tele-psychiatry room; however, a **12:00 p.m.** entry documents the detainee was lying down and quiet. Per entry to the medical record timed **11:00 a.m.**, SAMIMI was, in fact, evaluated by Dr. (b)(6);(b)(7)(C) (b)(6);(b)(7) in a tele-psychiatry encounter. The note documented he complained of feeling “stressed and depressed” and stated, “I want to die and not be here because of my methadone. I was on high doses for 28 years.” He was reminded mood symptoms were to be expected during withdrawal and that he would feel better over time. No psychosis was identified. The plan was to continue suicide level two, continue the medication protocol ordered by Dr. (b)(6);(b)(7)(C) and return to the clinic in one day. Asked for his theory on why an antidepressant medication was not prescribed by either psychiatrist, Dr. (b)(6);(b)(7) said that though not contraindicated, SAMIMI had no history of depression and adding another medication could aggravate stomach problems.

Per the Constant Watch Logbook, at **4:45 p.m.** the nurse checked his vital signs.

Note: The medical record does not document vital signs were taken at this time. Vital signs were next recorded at 4:00 a.m. on December 1, 2017.

At **5:37 p.m.** the Constant Watch Logbook documents SAMIMI had a legal call which ended at **6:15 p.m.** The start time of the call was five minutes earlier per the Medical Unit Logbook. The review team was informed by HSA (b)(6);(b)(7)(C) the call was transferred to the officer’s desk; therefore, there is no record of it. HSA (b)(6);(b)(7)(C) stated he overheard SAMIMI converse and answer questions immediately and with specificity. He believed that supported the theory that the detainee was faking the seriousness of his symptoms. RN (b)(6);(b)(7)(C) stated that after the call, she asked SAMIMI if it “went ok”. He smiled and said it had, and was “more upbeat”. The Constant Watch Logbook documents vital signs were taken at **6:30 p.m.**

Note: there is no corresponding documentation in the medical record.

The Constant Watch Logbook documents the detainee slept the rest of the evening.

Friday, December 1, 2017

Medical Unit Housing Record

SAMIMI did not accept breakfast or lunch but accepted dinner. He did not shower or attend recreation. Medical staff signed the log although the signature is illegible. No security supervisors signed the log for any shift this date.

MAR

Clonidine	Hydroxyzine	Immodium	Trazodone	Cyclo-benzaprine	Phenergan	Ibuprofen
9:00 a.m. 3:00 p.m. 9:00 p.m.	9:00 a.m.	None documented	None documented	9:00 a.m.	3:00 p.m.	9:00 a.m.

Note: The MAR established for December improperly sets 9:00 a.m., 2:00 p.m. and 9:00 p.m. as the administration times for as-needed medications hydroxyzine, Trazodone, cyclobenzaprine, and ibuprofen. The basis for administration of hydroxyzine, cyclobenzaprine, Phenergan, and ibuprofen is not reflected in the nursing notes.

Note: According to the MAR, the 9:00 p.m. dose of clonidine was refused. There is no reference to refusal in the nursing notes, nor is there a refusal form.

Vital Signs

Temperature	Pulse	Respirations	Blood Pressure	Oxygen	Weight
Not taken	84	16	101/64	96	Not taken
Not taken	94	18	Not taken	Not taken	Not taken
Not taken	Not taken	Not taken	112/68	Not taken	Not taken

By way of a 4:00 a.m. medical record entry discussed in entirety below, reviewers learned of an incident not logged in either the Medical Unit or Constant Watch Logbooks, nor did officers write incident reports. The incident as referenced by RN (b)(6);(b)(7)(C) involved SAMIMI “trying to drink from toilet,” falling to the floor, and “rolling on the ground.” The following summarizes video from the camera inside the cell immediately preceding and following the incident.

At **3:17 a.m.**, detainee SAMIMI is seen laying on a mattress on the floor with his head by the door. At **3:21 a.m.** he unsteadily sits up, takes his cup and reaches for the sink above the toilet. He then collapses to the floor onto his side. In so doing, his arm hit the toilet and his hand

dropped into the toilet water. He tries again to reach for the sink to get water. He brings the cup down from the sink then up to his mouth but the cup falls from his hand and into the toilet. He tries to fish the cup out of the toilet but again, falls back to the floor. A minute later, he pulls his hand out of the toilet and wipes it on his blanket. He was still on the floor with his head by the toilet.

At **3:23 a.m.**, the detainee again pulls himself into a sitting position but does not appear to have the strength to hold himself up. He falls back to a prone position. An officer³⁰ enters the cell. The officer goes to SAMIMI and from behind, assists him into a sitting position. The detainee then topples over onto his right side, narrowly missing the concrete wall with his head. The officer again assists SAMIMI into a sitting position and appears to motion to the detainee that he should slide towards the door and away from the toilet. SAMIMI instead lays back down. The officer then motions to someone outside the cell, presumably to get assistance. At **3:26 a.m.** the officer walks to the door and stands in the doorway, then leaves the cell. At **3:28 a.m.** the officer returns with a cup of water, sets it on the concrete bed slab and leaves the cell. At **3:30 a.m.** the detainee again pulls himself up and tries to reach the sink. He then takes the cup from the bed slab, takes a sip, sets the cup on the floor and collapses to the floor. At **3:31 a.m.**, RN Ross-Pearson enters with a cup. SAMIMI sits up but rests his head on the bed slab. RN (b)(6);(b)(7)(C) rubs his head and holds out the cup. SAMIMI then falls backward onto the floor. RN Ross-Pearson moves to assist, taking a position inadvertently blocking view of the detainee. Subsequent actions were as follows:

Time	Event
3:32 a.m.	Officer (b)(6);(b)(7)(C) enters the cell. The two officers and Nurse (b)(6);(b)(7)(C) grab hold of SAMIMI's legs and arms and slide him down toward the door of the cell so his head was away from the toilet. <i>Note: Officer (b)(6);(b)(7)(C) was the Medical Officer during the shift.</i>
3:33 a.m.	Officer (b)(6);(b)(7)(C) removes the Styrofoam meal container and returns to stand by the toilet.
3:34 a.m.	RN (b)(6);(b)(7)(C) re-enters the cell with the mobile blood pressure machine and places the cuff on the detainee's arm while he is on his side.
3:35 a.m.	Officer (b)(6);(b)(7)(C) hands the detainee a cup of water. The view is blocked; therefore, it is unknown if he drank any water.
3:39 a.m.	RN (b)(6);(b)(7)(C) removes the blood pressure cuff from the detainee's arm and wheels the blood pressure machine out of the cell.
3:40 a.m.	Officer (b)(6);(b)(7)(C) and RN (b)(6);(b)(7)(C) re-enter the cell and the nurse places an additional blanket over SAMIMI.
3:41 a.m.	Staff leave the cell.

³⁰ The Constant Watch documents the assigned officer was (b)(6);(b)(7)(C). First name is unknown.

Officer (b)(6);(b)(7)(C) was asked for an account of these events during interview. She said she was checking the monitor showing live-feed footage of the cells when she observed detainee SAMIMI urinating so she turned her head away. When she turned back, she observed him grab a cup and try to dip it in the toilet. She called for the Constant Watch officer to stop SAMIMI from drinking out of the toilet, and went to the nurses station to report the information to RN (b)(6);(b)(7)(C). She recalled the nurse replied, "Oh good thing he urinated." Per the nurse's instructions, the officer took ice chips to SAMIMI but he refused them. Officer (b)(6);(b)(7)(C) recalled the other officer wondering aloud when medical staff were going to come check on SAMIMI. About 10 minutes after the initial report that he was drinking out of the toilet, RN (b)(6);(b)(7)(C) arrived with the mobile vital signs monitor. Officer (b)(6);(b)(7)(C) said that when the nurse lifted SAMIMI's arm to take his blood pressure, he screamed, whereupon RN (b)(6);(b)(7)(C) told him to stop being difficult. Officer (b)(6);(b)(7)(C) reported that he screamed, "It hurts so fucking bad. I just want to die".

Note: The Constant Watch Logbook documents only that at **3:30 a.m.** SAMIMI was laying by the toilet "mumbling", and that the nurse checked his blood pressure and provided him with ice water and an additional blanket

RN (b)(6);(b)(7)(C) 4:00 a.m. progress note was the first of two medical record entries this date. She first addressed SAMIMI's phone call with his attorney, indicating the detainee appeared pleased. As noted previously, the call occurred the evening before. RN (b)(6);(b)(7)(C) wrote that SAMIMI slept through the night until 3:30 a.m. after which time he was observed talking to himself, trying to drink from toilet, falling to the floor, and rolling on the ground. She wrote that the medical officer accompanied her into the cell to prevent injury and offer water. A few minutes later he was asleep. When asked if he had a nightmare, he replied he did. The nursing plan was to continue to monitor every 15 minutes. Vital signs (see first row of the above chart) were all within normal limits.

During interview, RN (b)(6);(b)(7)(C) said she was very concerned by this point because SAMIMI was very weak and he had yet to see the physician. She said that leading up to this night, the detainee's increasing demands for "more, more, more" led her to conclude that he was drug-seeking, despite her best efforts to explain that medications may cause further stomach upset. She recalled that even when demanding more medication, he was never mean or belligerent. RN (b)(6);(b)(7)(C) said, "Do I wish I had sent him out? Yes. I haven't slept since." She added that her primary consideration in not doing so was the fact that SAMIMI's vital signs were good, so feared being criticized if she sent him to the emergency room.

Note: Other nurses cited SAMIMI's normal vital signs to support their decisions throughout the detention period. Dr. (b)(6);(b)(7)(C) also cited normal vital signs as evidence there was no clear cause that he should have been contacted following the incidents described above. As noted, clonidine may be responsible for having controlled SAMIMI's blood pressure.

(b)(6);(b)(7)(C) By e-mail timed 8:01 a.m., Lieutenant (b)(6);(b)(7)(C) notified Security Chief (b)(6);(b)(7)(C) that SAMIMI was offered and refused the breakfast meal, marking the third straight meal missed. Associate Warden (b)(6);(b)(7)(C) replied at 8:07 a.m. with the question, "Does ICE know this yet?" Security Chief (b)(6);(b)(7)(C) responded, "No they were not notified." Associate Warden (b)(6);(b)(7)(C) reply states, "I would make sure they are right after lunch so in the event he doesn't eat they're not blindsided over the weekend. We'll see if he eats lunch today. Thanks."

At **8:50 a.m.**, Supervisory Detention and Deportation Officer (SDDO) (b)(6);(b)(7)(C) signed the Medical Unit logbook noting, "All secure."

Note: SDDO (b)(6);(b)(7)(C) stated during interview that he did not speak with SAMIMI because he was on suicide watch and sleeping. He said he never met the detainee, but recalled he was discussed at the weekly meeting of department heads on November 29, 2017. It was reported at the meeting that he was on suicide watch and a life-long drug abuser.

In a **9:29 a.m.** progress note, RN (b)(6);(b)(7)(C) documented SAMIMI was on his way to the tele-psychiatry office when he "threw himself out of the wheelchair, landing on the floor face first." He sustained a nosebleed and urinated on himself. Pressure was applied to his nose with gauze until the bleeding stopped. According to the note, a blood pressure reading was not obtained because SAMIMI would not stay still. Other vital signs (see second row of above table) were within normal limits. RN (b)(6);(b)(7)(C) wrote that SAMIMI attempted to grab him with his bloody hands and was spitting. Dr. (b)(6);(b)(7)(C) arrived on the scene and ordered that SAMIMI be placed back into the suicide watch cell. The tele-psychiatry appointment was cancelled, and an appointment was scheduled with Dr. (b)(6);(b)(7)(C) psychologist, for the following day.

RN (b)(6);(b)(7)(C) was asked for his verbal account of this incident. He indicated that when he arrived at SAMIMI's cell to take him to the tele-psychiatry appointment, the detainee requested assistance in getting into the wheelchair. RN (b)(6);(b)(7)(C) indicated he declined to assist because he had a knee injury. He stated the detainee was able to get into the wheelchair without difficulty but moved slowly. Officer (b)(6);(b)(7)(C) stated during interview that he was present and witnessed SAMIMI ask for assistance getting in the wheelchair. He said RN (b)(6);(b)(7)(C) told him no and that he could do so by his own power. The officer confirmed SAMIMI moved slowly into the wheelchair, but fell out on the way to the appointment. As described by RN (b)(6);(b)(7)(C) SAMIMI lunged out of the wheelchair, falling on the floor. Questioned about this, he said the detainee "definitely lunged" because he landed at a distance which the RN believed required some effort. He said SAMIMI did not attempt to break his fall. RN (b)(6);(b)(7)(C) said the detainee urinated on himself and started bleeding from the nose, adding when asked that there were no other injuries such as a cut lip. He donned gloves and put gauze on SAMIMI's nose, and another nurse arrived to assist because the detainee was "rolling around." RN (b)(6);(b)(7)(C) said that when SAMIMI's arm hit the bill of his cap, he no longer felt safe because the detainee's hands were bloody and he could have poked him in the eye. According to RN (b)(6);(b)(7)(C) Dr. (b)(6);(b)(7)(C) arrived

and ordered SAMIMI's return to his cell and to level one suicide watch. RN (b)(6);(b)(7)(C) stated Dr. (b)(6);(b)(7)(C) neither assessed nor spoke with the detainee at this time.

During interview of Dr. (b)(6);(b)(7)(C) he confirmed he did not witness the incident but based on what was described by the RN, he was confident SAMIMI intentionally threw himself to the floor. He returned the detainee to level one suicide watch because the action could be interpreted as a suicidal gesture. Dr. (b)(6);(b)(7)(C) said that when he arrived on the scene, SAMIMI was "just laying there" looking at them.

The Medical Unit Logbook documents SAMIMI was returned to level one suicide watch per Dr. (b)(6);(b)(7)(C) at **10:00 a.m.**

There were no entries documenting the precipitating incident in either the Medical Unit or the Constant Watch Logbooks, and the latter does not include an entry documenting the change in status. Monitoring entries in the Constant Watch Logbook do, however, switch from every 15 minutes to every five minutes at 10:00 a.m., consistent with Constant Watch procedures. The log documents the detainee slept throughout the day until **3:35 p.m.** when the officer documented a nurse was talking with SAMIMI and provided Ensure at **3:40 p.m.** The officer noted the detainee took two drinks and spit the rest out.

Note: No corresponding nursing encounter is documented in the medical record.

At 3:55 p.m. the detainee took one drink of Ensure and spit the rest out. **At 4:40 p.m.** a meal was offered and refused. **At 5:05 p.m.** a nurse spoke with SAMIMI and he took medication at **5:10 p.m.**

Note: The medical record does not document an encounter with administration of a medication and as noted, MAR documentation does not allow determination of what medication was given at this time.

Officer (b)(6);(b)(7)(C) logged that he assumed the Constant Watch post at **7:06 p.m.** At **7:37 p.m.**, Officer (b)(6);(b)(7)(C) logged he noted SAMIMI was still wearing his full uniform when he removed the blanket. HSA (b)(6);(b)(7)(C) was consulted and informed the officer that per the doctor, the detainee was only supposed to have underwear. Officer (b)(6);(b)(7)(C) notified Lieutenant (b)(6);(b)(7)(C) and at **8:35 p.m.** they entered SAMIMI's cell together and removed the uniform. A suicide smock was issued.

HSA (b)(6);(b)(7)(C) completed a Suicide Alert – Level 1 form documenting special instructions to include:

- 1) Suicide smock;
- 2) Suicide pillow, gown, blanket;

- 3) Finger foods only;
- 4) Orange cup;
- 5) One paperback book or Bible – no metal;
- 6) Ten sheets of toilet paper at a time; and,
- 7) No sharps/no lethal items.

He also noted Dr. Wilson, psychologist, was to assess SAMIMI on December 2, 2017.

At **9:44 p.m.** Officer (b)(6);(b)(7)(C) documented that with the lieutenant's permission, he opened the door to give the detainee water. Entries thereafter documented SAMIMI was yelling intermittently then at **10:29 p.m.**, it was observed he appeared to be spitting up blood. Officer (b)(6);(b)(7)(C) documented he notified the medical officer and stated on interview that the officer notified the nurse. The nurse reportedly said she would see the detainee.

(b)(6);(b)(7)(C) **Note:** The medical record does not document a related nursing encounter.

At **11:17 p.m.** Officer (b)(6);(b)(7)(C) was relieved by Officer (b)(6);(b)(7)(C) as the Constant Watch Officer. Officer (b)(6);(b)(7)(C) documented in the logbook that at **11:34 p.m.** SAMIMI was complaining of stomach pain and "nurses not available." At **11:44 p.m.**, RN (b)(6);(b)(7)(C) responded to the cell, checked the detainee's vital signs and gave him medication.

Note: RN (b)(6);(b)(7)(C) did not respond for 75 minutes after SAMIMI was observed spitting up blood.

Note: RN (b)(6);(b)(7)(C) did not document her encounter with SAMIMI until 5:00 a.m. the next day.

Saturday, December 2, 2017

This was the day of SAMIMI's death.

(b)(6);(b)(7)(C) An incident report written by Officer (b)(6);(b)(7)(C) documents events which occurred during his shift. As noted above, he was the Constant Watch Officer for the shift starting 11:00 p.m. on December 1, 2017. The date the incident report was written and submitted is not documented. During interview, Officer (b)(6);(b)(7)(C) stated that because he had never seen a detainee as sick as SAMIMI, and because of what happened during the shift, he wrote an account in case it was needed later. The account was not documented in an incident report, but was turned in to Lieutenant (b)(6);(b)(7)(C) after Officer (b)(6);(b)(7)(C) learned of SAMIMI's death sometime in mid-December. He transferred the information to an incident report when requested, but as noted, did not record the date or document in the report that it was written based on notes made after his shift on

December 2, 2017. The reviewing supervisor did not sign the incident report until January 5, 2017.

Officer (b)(6);(b)(7)(C) report documents that he was told by the officer he relieved that SAMIMI had been refusing meals and not sleeping very much. He wrote, "From the moment I assumed the post, there was a strange odor emanating from his room which I assumed was vomit." Officer (b)(6);(b)(7)(C) wrote that when SAMIMI requested to see a nurse, RN (b)(6);(b)(7)(C) came to take his vital signs and commented, "It smells like he has liver failure." Officer (b)(6);(b)(7)(C) stated in his report that he figured that if that was the case, the detainee should be taken to the hospital. The nurse was unable to get a proper reading of the detainee's vital signs because he was unable to sit still. The detainee was given medications but the detainee was only able to swallow one. The remaining pills were left in a cup on the mattress. Officer (b)(6);(b)(7)(C) contacted the Watch Commander, Lieutenant (b)(6);(b)(7)(C), who instructed that he be kept informed and to let him know if the detainee eats breakfast.

Officer (b)(6);(b)(7)(C) incident report goes on to document that throughout the shift, detainee SAMIMI got up every few minutes complaining of stomach pains. Officer (b)(6);(b)(7)(C) wrote that he alerted medical staff on six different occasions that SAMIMI was in pain and requested more medication. Officer (b)(6);(b)(7)(C) documented that RN (b)(6);(b)(7)(C) told the detainee she could not give him additional medication until he consumed some food. She was able to check his vital signs and they were all normal. According to the report, the nurse stated the detainee was "dehydrated and hungry."

Officer (b)(6);(b)(7)(C) wrote that later in his shift, the detainee dragged himself to the toilet but he could not see what the detainee was doing. SAMIMI asked him to bring his medicine and then vomited into the toilet. Officer (b)(6);(b)(7)(C) notified the medical officer to alert nursing staff. When they came to check on him "for a third time", they noticed SAMIMI had been incontinent of urine. The wet mattress was removed from the cell and coffee spilled on the floor was mopped up by Officer (b)(6);(b)(7)(C) and another officer. Officer (b)(6);(b)(7)(C) documented that when nursing staff left the detainee's cell, the other officer asked LPN (b)(6);(b)(7)(C) what is wrong with the detainee to which she replied, "He's dying." The officer then asked why 911 was not being called but neither nurse responded. Officer (b)(6);(b)(7)(C) noted in his report that this was the second time he thought 911 should be called but nursing staff did not agree.

The incident report states that when breakfast was served, SAMIMI initially refused to eat. Officer (b)(6);(b)(7)(C) told the detainee he needs to eat in order to get his medicine, so SAMIMI "began to eat his breakfast" and drank a little bit of water. This information was reported to Lieutenant (b)(6);(b)(7)(C).

Note: In an email to facility leadership at 5:27 a.m., Lieutenant (b)(6);(b)(7)(C) documented SAMIMI ate "half of his breakfast this date."

Officer (b)(6);(b)(7)(C) ended his Incident Report by noting he informed his relief, Officer (b)(6);(b)(7)(C), of “everything that occurred during my shift” and told the officer to “keep a good eye” on SAMIMI because he had missed four meals and was vomiting. (b)(6);(b)(7)(C)

Lieutenant (b)(6);(b)(7)(C) was interviewed concerning his recollection of events during the shift. He said he recalled being asked to come to the post by Officer (b)(6);(b)(7)(C) and that the officer was “very concerned.” Lieutenant (b)(6);(b)(7)(C) also recalled seeing the medications on the bed and spoke with the nurse. He asked what was going on because the officers were saying the detainee was suffering. He was told Dr. (b)(6);(b)(7)(C) was aware of the situation and planned to see SAMIMI. Lieutenant (b)(6);(b)(7)(C) said that in retrospect, he wished he had called 911 himself but did not because he was told Dr. (b)(6);(b)(7)(C) was fully informed. He commented he has “had battles with Dr. (b)(6);(b)(7)(C) in the past” and has lost; consequently, he knows his “boundaries.” (b)(6);(b)(7)(C)

The review team also interviewed LPN (b)(6);(b)(7)(C) concerning her involvement in the events documented by Officer (b)(6);(b)(7)(C). She recalled nursing staff were handling a very heavy volume of admissions that night and that RN (b)(6);(b)(7)(C) said she would come to intake assist; however, she was delayed because “Mr. Samimi was having problems.” When LPN (b)(6);(b)(7)(C) had the opportunity, she went to medical to “see what was going on.” She remembered Officer (b)(6);(b)(7)(C) calling for a nurse and that she and RN (b)(6);(b)(7)(C) went to the cell. The RN said, “let’s get him up on the bed,” then they noticed the floor was wet and she stepped in the liquid, asking, “What’s that?” LPN (b)(6);(b)(7)(C) said SAMIMI “didn’t look good”, was very agitated, and did not want the nurses there. When apprised of the comment, “He’s dying” attributed to her by Officer (b)(6);(b)(7)(C), LPN Numongo replied, “Oh my goodness! Did I say that?” She noted that sometimes in a stressful situation people will say inappropriate things and offered that it was certainly an inappropriate, very regrettable comment.

RN (b)(6);(b)(7)(C) documented the events of the night in a **5:00 a.m.** progress note. She wrote that SAMIMI screamed for nurses and complained of abdominal pain. Pain level was not obtained. Vital signs were recorded as follows: temperature 98.2, pulse 92, respirations 17, blood pressure 113/68, and oxygen saturation 94 percent, all within normal limits with the exception of a lowered oxygen level. SAMIMI’s lungs were clear to auscultation, and bowel sounds were present in all four quadrants.

Note: RN (b)(6);(b)(7)(C) did not document the time this assessment was conducted.

The note goes on to state that several times during the night SAMIMI screamed that he was unable to breath, for which a re-breather³¹ was provided. He pulled it off and went back to sleep. At 3:30 a.m. he woke up a third time screaming for Zantac and an injection for nausea. His vital

³¹ A rebreather is a mask with an attached reservoir bag that saves one third of a person’s exhaled air, while the rest of the air gets pushed out through side ports covered with a one-way valve. This allows the person to rebreathe some of the carbon dioxide exhaled, which acts as a way to stimulate breathing.

signs at were recorded as follows: pulse 100, respirations 17, blood pressure 92/68, and oxygen saturation 95 percent, all within normal limits. A body temperature was not obtained. He was given Zofran for nausea 4 mg intramuscularly per verbal order of Dr. (b)(6);(b)(7)(C) to treat the nausea, as he was unable to swallow the Phenergan. RN (b)(6);(b)(7)(C) documented the verbal order "OK'd by MD".

Note: The order was never authenticated by Dr. (b)(6);(b)(7)(C) and the prescription is incomplete as it does not indicate if this was a stat, as-needed, or regularly scheduled dose.

RN (b)(6);(b)(7)(C) noted that SAMIMI did not receive his nighttime dose of Trazodone.

Officer (b)(6);(b)(7)(C) entries to the Constant Watch Log for the remainder of his shift documented that at **6:16 a.m.**, SAMIMI was vomiting in the toilet and stopped after one minute. The nurse was notified. At **6:44 a.m.**, Officer (b)(6);(b)(7)(C) documented the detainee was vomiting again and that the nurse was notified.

The Constant Watch log documents Officer (b)(6);(b)(7)(C) assumed the post at **7:06 a.m.** He logged SAMIMI was eating at **10:15 a.m.** At **10:35 a.m.** his entry documents, "Yelling and screaming of tummy pain, I notified the nurse (vomiting!)". The **10:40 a.m.** entry documents SAMIMI was "Yelling and screaming for nurse, nurse notified"; at **10:45 a.m.**, "Yelling and screaming for nurse/called Lt. (b)(6);(b)(7)(C)"; and at **10:50 a.m.**, "Yelling and screaming for nurse".

According to medical record entries (detailed below) and written and verbal reports of Officer (b)(6);(b)(7)(C) and Medical Officer (b)(6);(b)(7)(C), Officer (b)(6);(b)(7)(C) was asked to take SAMIMI to an 11:00 a.m. appointment with Dr. (b)(6);(b)(7)(C) PhD Psychologist. Both officers stated Officer (b)(6);(b)(7)(C) refused because he believed SAMIMI was too unstable to move. During interview, Officer (b)(6);(b)(7)(C) explained that he was the Constant Watch officer the previous day and was aware of the incident where it was believed SAMIMI was drinking from the toilet, as well as his return to Level one suicide watch after falling from his wheelchair. Officer (b)(6);(b)(7)(C) said he observed SAMIMI was in an extremely weakened condition and reported his observation to nursing staff, but nurses thought the detainee was faking. Officer (b)(6);(b)(7)(C) commented SAMIMI seemed to have further declined when he assumed the post on this date, stating that in fact, he "kept looking at him" to make sure the detainee was breathing. Officer (b)(6);(b)(7)(C) did not want to incur the risk of moving SAMIMI on his own, so he asked for the assistance of a nurse. In Officer (b)(6);(b)(7)(C) report, she documented that she notified RN (b)(6);(b)(7)(C) retrieved a wheelchair, and they both went to SAMIMI's cell. Officer (b)(6);(b)(7)(C) recalled that when the nurse arrived, he told SAMIMI he had an appointment and that they would put him in a wheelchair. Both officers reported that the detainee was moved to the wheelchair, but then stiffened. He was moved back to the mattress. Officer (b)(6);(b)(7)(C) stated there was a substance of some sort on his forearm because SAMIMI's face brushed it as they moved him into the wheelchair. Officer (b)(6);(b)(7)(C) remained at the cell while Officer (b)(6);(b)(7)(C) left the scene to wash it off.

Video from inside the cell starting at **10:51 a.m.** was viewed to corroborate the officers' accounts of these and subsequent events. At the time the video starts, SAMIMI is sitting on a mattress on the floor with his head resting on a second mattress on top of the bed. He was wearing socks and underwear. The following events occurred:

Time	Event
10:52 a.m.	Detainee lays down on the mattress on floor, grabbing a blanket to cover himself.
10:53 a.m.	The officer opens the cell door, closes it, and re-opens it.
10:55 a.m.	RN (b)(6);(b)(7)(C) enters and hands SAMIMI a small cup. SAMIMI sits up, takes the cup, and appears to ingest the contents. He lays back down. <i>Note: per the logbook, the cup contained medication.</i>
10:56 a.m.	RN (b)(6);(b)(7)(C) stands in the doorway and motions for SAMIMI to get up. RN (b)(6);(b)(7)(C) pulls the blanket off him. SAMIMI moves to his knees and appears to speak to the nurse.
10:57 a.m.	RN (b)(6);(b)(7)(C) leaves the cell. SAMIMI remains in a kneeling position with his head on the mattress.
10:58 a.m.	RN (b)(6);(b)(7)(C) returns with suicide smock. SAMIMI stands, stumbles and reaches out to the nurse for support, grabbing the nurse's arm. He then collapses to the floor in the doorway and is assisted to his feet by Officers (b)(6);(b)(7)(C) and (b)(6);(b)(7)(C) and RN (b)(6);(b)(7)(C). They move him to the wheelchair outside the cell door.
10:59 a.m.	SAMIMI is helped to a sitting position in the wheelchair. His head then rolls back and his leg stiffen and appear to shake. He then slides out of the wheelchair, feet first. He is caught by the staff before reaching the floor, then is carried back into the cell and placed on the mattress on the floor. RN (b)(6);(b)(7)(C) picks up the medication cup that had been left on the bed and covers SAMIMI with a blanket. SAMIMI moves the blanket up over his head, concealing his face. His right arm and both legs are still visible and movement of the limbs is seen.
11:00 a.m.	Officer (b)(6);(b)(7)(C) removes a Styrofoam food container and a cup from the cell. The cell door is closed, then re-opened as RN (b)(6);(b)(7)(C) stands in the doorway looking into the cell. Officer (b)(6);(b)(7)(C) is seen on camera pointing at his own arm and then walks away.

RN (b)(6);(b)(7)(C) medical record entry addressing these and subsequent events is timed 12:30 p.m. He documents that he and the officers "tried to assist to transfer detainee from the floor where he was sleeping on the mattress to the wheelchair. The detainee was very weak. The nurse told the officers to leave detainee on the mattress on the floor." During interview of RN (b)(6);(b)(7)(C) about events to this point, he confirmed Officer (b)(6);(b)(7)(C) asked for his assistance in getting SAMIMI to his appointment with Dr. (b)(6);(b)(7)(C) indicating the detainee could not walk. RN (b)(6);(b)(7)(C) indicated

he did not know the detainee could not walk, so he went to the cell with Officer (b)(6);(b)(7)(C). He said they attempted to place SAMIMI in the wheelchair but could not move him from the floor because he became stiff. When shown the video of SAMIMI's placement in the wheelchair, immediately followed by his stiffening and appearing to shake, RN (b)(6);(b)(7)(C) acknowledged his recollection was incorrect. Asked about the possibility that SAMIMI experienced a seizure, RN (b)(6);(b)(7)(C) said he had not considered it because the detainee had no known seizure history.

The next events as shown on the video were as follows:

Time	Event
11:01 a.m.	Officer (b)(6);(b)(7)(C) and RN (b)(6);(b)(7)(C) re-enter the cell. RN (b)(6);(b)(7)(C) grabs the detainee's arm and lifts him to move him onto his right side, then leaves the cell.
11:02 a.m.	Officer (b)(6);(b)(7)(C) leans down and appears to speak to the detainee.
11:03 a.m.	Officer (b)(6);(b)(7)(C) returns to the cell and stands in the open doorway.
11:04 a.m.	RN (b)(6);(b)(7)(C) returns to the cell door and hands Officer (b)(6);(b)(7)(C) several cloths. Officer (b)(6);(b)(7)(C) bends down and begins to clean the detainee's head, face and mattress. As this occurs, RN (b)(6);(b)(7)(C) stands in the hallway, briefly watches as the officer cleans SAMIMI, then he walks away.
11:05 a.m.	RN (b)(6);(b)(7)(C) returns to the cell doorway and Officer (b)(6);(b)(7)(C) points to a dark spot on the detainee's suicide smock. The nurse picks up the smock, which appears to have a large wet spot on it, then moves SAMIMI by the arm so his face could be seen. RN (b)(6);(b)(7)(C) uses a cloth to wipe SAMIMI's mouth area and leaves the cell.
11:06 a.m.	Officer (b)(6);(b)(7)(C) cleans SAMIMI's hand with a cloth.

During interview of Officer (b)(6);(b)(7)(C) about these events, she said she heard a choking sound immediately after they left the cell and called for RN (b)(6);(b)(7)(C) to return. RN (b)(6);(b)(7)(C) said he was returning to his office when called back to the scene. SAMIMI was turned on his side and vomited. Officer (b)(6);(b)(7)(C) stated she observed blood clots in the vomit and pointed this out to RN (b)(6);(b)(7)(C). Officer (b)(6);(b)(7)(C) stated that he returned to the cell after SAMIMI was moved to his side and observed vomit on his face. According to both officers, Officer (b)(6);(b)(7)(C) told the nurse he should call the doctor. RN (b)(6);(b)(7)(C) agreed and left to do so. Officer (b)(6);(b)(7)(C) informed the review team that she contacted Lieutenant (b)(6);(b)(7)(C) at this point to request that he come to medical, although her written report suggests the contact was made after SAMIMI was first returned to the cell. Lieutenant (b)(6);(b)(7)(C) was the Watch Commander for the 7:00 a.m. to 3:00 p.m. shift this date.

In his 12:30 p.m. medical record entry, RN (b)(6);(b)(7)(C) addresses these events by stating that around 11:08 a.m., the officer reported SAMIMI was vomiting. He and the officer repositioned the detainee to his side and he instructed the officers to clean the vomit and keep their eye on detainee. During interview, RN (b)(6);(b)(7)(C) stated he was called back into the cell after leaving for

his office upon report SAMIMI was vomiting. He said the vomitus consisted of stomach contents only and that there was no blood. RN (b)(6);(b)(7)(C) said he decided to call Dr. (b)(6);(b)(7)(C) at this point, indicating he did not call 911 because the situation was not a "super emergency." His intent in calling Dr. (b)(6);(b)(7)(C) was to notify him that alternative placement should be sought for SAMIMI because his needs exceeded DCDF's capability to handle.

Officer (b)(6);(b)(7)(C) documented in the medical unit log that at **11:05 a.m.** Dr. (b)(6);(b)(7)(C) was informed the detainee is not stable enough to see him as he was unable to sit in the wheelchair. In Dr. (b)(6);(b)(7)(C) medical record entry, he wrote that when first informed of the attempt to place SAMIMI in a wheelchair, he said he would go to the cell to conduct the evaluation. However, shortly thereafter, security advised him that he was lying on the floor vomiting up blood, with nursing staff tending to him and attempting to contact the doctor.

At **11:06 a.m.**, Officer (b)(6);(b)(7)(C) logged that Lieutenant (b)(6);(b)(7)(C) arrived. The lieutenant confirmed during interview and documented in his written report that Officer (b)(6);(b)(7)(C) contacted him by radio and asked him to report to medical. He was in his office at the time and was able to respond immediately. While en route to medical, Lieutenant (b)(6);(b)(7)(C) encountered Officer (b)(6);(b)(7)(C) who was also on his way to medical. Officer (b)(6);(b)(7)(C) stated on interview that he was in the control center when the officer watching the camera monitors questioned aloud whether Officer (b)(6);(b)(7)(C) should be touching a detainee's head. Officer (b)(6);(b)(7)(C) looked at the monitor and confirming (b)(6);(b)(7)(C) appeared to be touching the detainee's head, decided to report to medical to inform the officer this was improper. According to Officer (b)(6);(b)(7)(C), he was cleaning SAMIMI's face as directed by RN (b)(6);(b)(7)(C).

The video shows Lieutenant (b)(6);(b)(7)(C) and Officer (b)(6);(b)(7)(C) arriving on scene and looking in the cell at **11:07 a.m.** Officers (b)(6);(b)(7)(C) and (b)(6);(b)(7)(C) are seen speaking to the lieutenant, then Officer (b)(6);(b)(7)(C) enters the cell and removes the blanket from SAMIMI who remained on his right side.

During interview, Officer (b)(6);(b)(7)(C) commented that he was concerned there could be a security issue, so he entered the cell to look for anything that could be used as a weapon. Lieutenant (b)(6);(b)(7)(C) informed the review team and documented in his written statement that when he looked in the cell SAMIMI was lying on his right side on a mattress on the floor. He noted the detainee's eyes were open and he looked pale. The lieutenant stated to the review team that "the guy was clearly in crisis," noting there was vomit on the side of the detainee's face, he had urinated, and was breathing heavily. The lieutenant reported that he said, "We need an ambulance" and asked the officers where the nurse was. They replied that he had gone to call the doctor, whereupon the lieutenant proceeded to the nurses' station and said to RN (b)(6);(b)(7)(C) "What are you doing? We need an ambulance." The RN said he had left messages for Dr. (b)(6);(b)(7)(C) and was trying to reach the HSA. Lieutenant (b)(6);(b)(7)(C) stated that an ambulance was needed and went to another phone in medical to direct Central Control to call 911. Officer (b)(6);(b)(7)(C) left to prepare for the hospital detail.

According to RN (b)(6);(b)(7)(C) 12:30 p.m. progress note, he left messages on Dr. (b)(6);(b)(7)(C) home and mobile phones asking for a return call. Dr. (b)(6);(b)(7)(C) stated during interview that he did not receive the messages. RN (b)(6);(b)(7)(C) documented that he then called HSA (b)(6);(b)(7)(C) who ordered that 911 be called. RN (b)(6);(b)(7)(C) informed the review team that after speaking with HSA (b)(6);(b)(7)(C) he went back to the cell area and found Lieutenant (b)(6);(b)(7)(C) was there. He told the lieutenant that he received the order for SAMIMI to go to the hospital, whereupon the lieutenant asked if the detainee could "support his own weight." When told he could not, the lieutenant called 911 for him. Reviewers note RN (b)(6);(b)(7)(C) account of events leading to calling for an ambulance is inconsistent with Lieutenant (b)(6);(b)(7)(C), and not supported by any other evidence, written or reported.

(b)(6);(b)(7)(C) was the Central Control Officer. He confirmed that on camera, he observed Officer (b)(6);(b)(7)(C) touching SAMIMI about the head. He stated that when Officer (b)(6);(b)(7)(C) left to investigate, he continued to watch events in the cell on the monitor. Based on what he observed, he knew when Lieutenant (b)(6);(b)(7)(C) called that it was about SAMIMI. Per Officer (b)(6);(b)(7)(C) logbook entry and incident report, he received the instruction to call 911 at 11:10 a.m. He reported the intake area was subsequently locked down so he could override the gates and let Emergency Medical Services (EMS) responders in quickly.

Lieutenant (b)(6);(b)(7)(C) reported that after he instructed the control officer to call 911, he returned to cell 527 where he observed detainee SAMIMI was breathing. He said he observed vomit on and near his face, and that there may have been blood on the floor. He told the detainee to lie still as an ambulance was on the way. The Lieutenant then went to the armory to issue weapons to Officers (b)(6);(b)(7)(C) and (b)(6);(b)(7)(C) who would be accompanying the detainee to the hospital, one in the ambulance and the other in the chase vehicle. Lieutenant (b)(6);(b)(7)(C) also assigned perimeter patrol Officer (b)(6);(b)(7)(C) to report to the perimeter gate to escort the paramedics into the facility. Officer (b)(6);(b)(7)(C) stated on interview that he opened the perimeter gates for the EMS responders and escorted them through the intake area and into medical.

The report of the Aurora Fire Department documents a team consisting of two Emergency Medical Technician (EMT) paramedics and two EMT basic responders was dispatched at 11:16 a.m., arriving on scene at 11:18 a.m. Officer (b)(6);(b)(7)(C) documented the same time of arrival in the Central Control logbook. The in-cell video shows the following events prior to and upon EMS arrival.

Time	Event
11:09–11:15 a.m.	SAMIMI moves his arms and legs and rolls from his side to his back, then to his stomach.
11:15-11:18 a.m.	SAMIMI is on his stomach. Very little movement is observed.
11:18:03 a.m.	RN (b)(6);(b)(7)(C) enters the cell, pulls SAMIMI's arm to turn him slightly. He looks at the detainee's face then releases the arm.

11:18:35 a.m.	SAMIMI's head moves slightly.
11:18:51 a.m.	An EMT enters the cell and shakes the detainee by the shoulder. He then turns SAMIMI onto his back and checks for a pulse. A second EMT enters. The first EMT then pulls the detainee by his arms out into the hallway.
11:19:48 a.m.	EMTs started chest compressions and administer medications in the hallway.

The Aurora Fire Department (AFD) report documents that upon arrival on scene, the EMTs found SAMIMI "lying prone in the holding cell with emesis on the mattress." He was unresponsive and pulseless with no obvious signs of trauma. SAMIMI was given cardiopulmonary resuscitation (CPR) and a Basic Life Support airway was put in place. It was noted SAMIMI had "coffee ground type emesis" and he was continuously suctioned to clear the airway. Epinephrine was given and CPR was continued with a delay when the detainee was moved from the floor onto a pram and out to the ambulance. The provider's impression was noted in the report as cardiac arrest. The in-cell video shows he was out of camera range at 11:32 a.m.

The Falk Rocky Mountain EMS also responded. According to the responders' report, detainee SAMIMI was lying supine on the ground with CPR in progress by AFD personnel on their arrival. AFD reported the detainee had agonal³² respirations at a rate of two per minute, and the monitor showed him to be in asystole³³. He received a total of nine rounds of CPR, remaining in asystole until the eighth round, at which time he was in ventricular fibrillation³⁴. He was shocked once and upon the next rhythm check, he was back in asystole. He was transported to the emergency room at the University of Colorado Health Medical Center.

Video footage from the camera in the Medical West Hallway shows EMS responders working on SAMIMI outside the cell. At **11:27 a.m.** two additional responders arrive. At **11:29 a.m.** the Aurora Police Officer motions for Officer (b)(6);(b)(7)(C) to meet him at the end of the corridor. Officer (b)(6);(b)(7)(C) is seen speaking with the officer and showing him the logbook and the detainee's identification information. The two speak for approximately six minutes while rescue efforts continued behind them.

At **11:33 a.m.** the detainee is lifted in the pram onto the gurney and the gurney is wheeled off the unit. At **11:34 a.m.**, Officers (b)(6);(b)(7)(C) and (b)(6);(b)(7)(C) speak to each other and Officer (b)(6);(b)(7)(C) makes entries in the logbook. An unidentified nurse approaches them and the officers appear to re-enact the incident when the detainee stiffened as he was being placed into the wheelchair. At **11:38 a.m.**, RN (b)(6);(b)(7)(C) approaches the two officers and he and Officer (b)(6);(b)(7)(C) hug. The video ends at **11:39 a.m.**

³² Agonal breathing refers to labored breathing, characterized by gasping.

³³ Asystole, also known as cardiac flat line, is the absence of heart contractions.

³⁴ Ventricular fibrillation is a life-threatening heart rhythm that results in a rapid, inadequate heartbeat.

Lieutenant (b)(6);(b)(7)(C) reported EMS responders were performing CPR when he returned to medical. He asked Officer [redacted] what happened and was told SAMIMI was breathing but stopped when the paramedics arrived. RN (b)(6);(b)(7) 12:30 p.m. progress note also documents SAMIMI was breathing when the paramedics arrived but then stopped. Lieutenant (b)(6);(b)(7)(C) notified the Warden, Associate Warden and Security Chief by telephone and then escorted the EMS responders to the ambulance. According to the DCDF transport log, the ambulance left the facility at **11:40 a.m.**

Officer (b)(6);(b)(7)(C) rode in the ambulance. She reported on interview that she sat in the front passenger seat because the EMS responders needed available space in the back area to continue working on SAMIMI. She recalled the ambulance activated lights but no siren en route to the hospital. The transport log documents they arrived at the University of Colorado Medical Center (UCMC) at **11:45 a.m.**

According to the emergency room record, EMS responders reported the patient was breathing roughly two times a minute and they immediately started CPR, continuing for 19 minutes. On arrival at the emergency room he had fixed pupils and was in asystole. His preliminary diagnosis was cardiac arrest. The emergency room record states black vomitus noted on his face and in his airway suggested a possible gastro-intestinal bleed.

At **12:02 p.m.** detainee SAMIMI was pronounced dead. According to RN (b)(6);(b)(7) 12:30 p.m. progress note, notification of death was provided by UCMC physician Dr. (b)(6);(b)(7)(C). At **2:32 p.m.** the detainee was taken to the morgue by hospital staff and the assigned officers returned to the facility.

Note: The DCDF MAR documents SAMIMI was given a dose of ibuprofen at 2:00 p.m. and clonidine at 3:00 p.m. As noted, he left the facility at 11:40 a.m. and death was pronounced at 12:02 p.m.

Post-Death Events

- Lieutenant (b)(6);(b)(7)(C) collected incident reports from all officers involved in events leading to SAMIMI's medical emergency and wrote his own.
- A letter was sent to SAMIMI's sister on December 11, 2017, notifying her of his death. Per the Resident Account report 2018 a check for \$22.00 was sent to (b)(6);(b)(7)(C) on January 4, 2018.
- Warden Johnny Choate personally met with each member of involved security staff and provided information on available employee assistance services. He did not, however, meet with nursing staff. HSA (b)(6);(b)(7)(C) said he spoke with certain nurses who were

impacted by the death but the discussions were “more informal” and did not include referral to employee assistance services. Warden Choate acknowledged he should have spoken with nursing staff as well as officers.

- The facility conducted two after action reviews. Video surveillance footage was not reviewed for either. The first, dated December 6, 2017, was conducted at the Monthly Safety Committee Meeting. This report found, “Medical and security staff acted properly as directed by policy and procedures. Several Department Heads at the facility were unaware of the incident until later in the week.” Noted remedial action was for the Warden to notify all department heads by email of any future serious incidents.
- The second report, dated December 18, 2017, is titled Multi-Level Mortality Review. The report was signed by review committee members Warden Choate, Dr. (b)(6);(b)(7)(C) HSA (b)(6);(b)(7)(C) RN (b)(6);(b)(7)(C) and (b)(6);(b)(7)(C), identified in the signature block as responsible for quality assurance. The report was directed to the GEO Chief Medical Officer and the Executive Vice President of Health Services. No security or ERO personnel were involved in this review. The report is based on documented information in the medical record and medical staff report, although the basis for some of what is documented is unclear or not supported.
 - The report lists the presumptive cause of death as, “Asphyxiation Secondary to Broncho Aspiration of Gastric Contents”. The cause of death is not attributed on the document, although Dr. (b)(6);(b)(7)(C) acknowledged on interview that it was his based solely on observations reported by staff.
 - Methamphetamine use is referenced in the admitting diagnosis section of the report and included in specific information relevant to death. Nowhere in the medical record is it documented SAMIMI used methamphetamines.
 - “Specific information as relevant to death” includes the statement, “Presented to this facility experiencing acute withdrawal symptoms of blurred vision, shaking extremities, nausea and vomiting.” Reviewers note that although symptoms of withdrawal were observed within hours of SAMIMI’s arrival at DCDF and progressed thereafter, documentation and verbal statements do not support that he was experiencing blurred vision, shaking extremities, nausea and vomiting when he arrived at the facility or during intake screening.
 - The document states, “Appeared to progress well with withdrawal protocol, began demanding ‘stronger medications’”. Reviewers note that the basis for the statement that he appeared to progress well is not supported by the medical record. Although not clearly addressed in the medical record, security and video documentation suggest SAMIMI’s withdrawal symptoms progressively worsened.
 - The document states, “Sporadic ingestion of food and drink, appeared unable to cooperate with psychologist and psychiatrist evaluations, but able to sit and speak with attorney.” Reviewers note that SAMIMI fully cooperated with Dr. (b)(6);(b)(7)(C).

during his initial mental health examination on November 20, 2017. While en route to his follow up appointment on November 28, 2017, SAMIMI collapsed and was determined too unstable to proceed with the evaluation by the psychologist, with concurrence by the physician. The next mental health appointment was completed via tele-psychiatry on November 29, 2017 following the detainee's suicide attempt. The medical record documents SAMIMI's cooperation. Likewise, the record documents his cooperation with the next mental health appointment on November 30, 2017. While en route to the final mental health appointment on December 1, 2017, SAMIMI fell from his wheelchair. The nurse's observation was that he "lunged", suggesting the fall was not for medical reasons. Whether it was or was not cannot be determined, although events during the preceding hours suggest he was very ill. The reviewers conclude that the statement in Multi-Level Mortality Review that the detainee "appeared unable to cooperate with psychologist and psychiatrist evaluations" is not supported by the medical record.

- Regarding events on December 2, 2017, the document describes events in a manner inconsistent with information reported by officers and RN (b)(6);(b)(7)(C). It states, "Samimi was being prepared for a psychology evaluation. Nursing staff and detention officers attempted to move him from his bedding he had placed on the floor into a wheelchair; Samimi was unable to sit in the wheelchair and was returned to the mattress. The psychologist volunteered to conduct the evaluation in the cell. Noting Samimi's condition the nurse went to call the physician for orders, he was summoned by the detention officers who informed him Samimi had vomited. The nurse returned to the cell, repositioned Samimi on his side and removed the vomitus from his mouth, and asked the detention officers to watch him and returned to the phone. The HSA was contacted and gave instructions to send Samimi out. The Shift Commander called control and instructed the control officers to call 911." Based on documented and reported information, RN (b)(6);(b)(7)(C) did not attempt contact with the physician until after he returned to the cell and SAMIMI was found to have vomited. While accurate that the Shift Commander instructed calling 911, evidence indicates he did so prior to the RN's receiving authorization from the HSA as implied in the Mortality Review.
- In the section, "Institution Medical Care Review", "poor" is marked for prognosis with treatment. Whereas the physician did not evaluate SAMIMI, and nothing in the medical record suggests nursing staff assessed the detainee's prognosis as poor and made appropriate referrals, the documentation on the Mortality Review is unexplained.
- In the section, "Any complications adversely affecting outcomes", "yes" is marked with the description, "After withdrawal completed began demanding medications. Made suicidal gesture." The medical record does not document or support that withdrawal was ever completed; in fact, Dr. (b)(6);(b)(7)(C) stated during interview that SAMIMI was still in withdrawal on the day he died. Also, the

medical record does not document determination that SAMIMI's actions on November 30, 2017 were a suicidal gesture versus a suicide attempt.

- Entries in the section, "Review of Emergency Medical Care" appear non-responsive or unclear. Yes is checked for CPR, although no DCDF personnel administered CPR. Yes is checked for "Problems encountered during medical emergency, e.g.; equipment, communications, and transportation?" with the description, "EMS team reported presence of 'vomit' in airway during resuscitation effort." Based on all available information, CPR was not initiated by DCDF personnel because SAMIMI was reportedly breathing when EMS arrived, and no problems with equipment, communications, or transportation were identified.
- The Mortality Review inaccurately documents SAMIMI became unresponsive after he was placed on the EMS gurney. In fact, he became unresponsive before he was moved to the EMS gurney.

The Mortality Review findings identified as the sole strength, "Quick initiation of withdrawal protocol. Monitoring of detainee while on withdrawal protocol." The ERAU review team concurs that the physician was contacted and a withdrawal protocol was initiated quickly. However, as identified above and discussed below, the physician did not fully follow the CPG protocol and nursing monitoring was inadequate.

The Mortality Review includes one recommendation: "Re-emphasize to all nursing staff, use your clinical judgment and call 911 when presented with a life or death situation."

Dr. (b)(6);(b)(7) and HSA (b)(6);(b)(7) stated they did not review any video footage prior to or following completion of the Mortality Review.

Staff Comments

Reviewers found comments made by both medical and security personnel provided instructive context for events described above. Highlights include the following:

- SAMIMI was overwhelmingly described as cooperative, respectful and pleasant. The few exceptions were occasions when he demanded medical attention to address withdrawal symptoms.
- Although Dr. (b)(6);(b)(7) never examined SAMIMI, he said he had casual contact with the detainee almost every day, speaking to him through the glass window of the cell or in the hallway. He said nurses kept him informed of SAMIMI's progress and actions and that based on what he was told, he believed the detainee engaged in "behavior to get what he wanted." Dr. (b)(6);(b)(7) said the two fainting spells were "not legitimate", referring to the

November 24, 2017 incident when SAMIMI was observed by the officer and on video sliding to the floor in his cell, and the incident on December 1, 2017 when he “threw himself” out of the wheelchair. Dr. (b)(6);(b)(7) said he repeatedly heard from nurses and SAMIMI that he wanted methadone. He indicated he considered but dismissed the idea of a methadone detoxification regimen because of the dose SAMIMI reported taking and because he was unable to verify the detainee was getting it legitimately. He believed SAMIMI was progressing through withdrawal well despite his demand for stronger medications and he had no reason to believe nursing staff were not administering the medications he ordered. Dr. (b)(6);(b)(7) remarked, “Maybe in the last 48 hours a nurse should have called him,” but SAMIMI was doing pretty well when he left the facility on Friday.

- HSA (b)(6);(b)(7) said he was also the recipient of information from nurses which led him to believe SAMIMI “did a bit of acting.” He said that at one point, he observed that the detainee seemed to look around to see who was watching, then acted disoriented. He believed that what he observed and overheard when SAMIMI spoke with his attorney on November 30, 2017 supported the prevailing opinion that some of the detainee’s actions were exaggerated and manipulative. HSA (b)(6);(b)(7) indicated SAMIMI was withdrawing “pretty effectively”, then deteriorated.
- Dr. (b)(6);(b)(7) and HSA (b)(6);(b)(7) both emphasized that clinical services provided at DCDF are ambulatory and that the medical housing unit is not an infirmary. Dr. (b)(6);(b)(7) also stressed that they are not set up to handle patients with health care needs requiring housing in medical for indefinite periods of time. For that reason, and because he believed SAMIMI was progressing well, he considered discharging him from the medical housing unit. He did not do so because he was concerned about the tremors nurses observed.
- Dr. (b)(6);(b)(7) and HSA (b)(6);(b)(7) expressed overall confidence in the nursing staff, although they noted work volume sometimes stretches resources. They said turnover is higher than desirable and that the process for completing background investigations is slow. Due to the long term vacancy in the Director of Nurses position, all nurses answer directly to HSA (b)(6);(b)(7) on administrative matters and to Dr. (b)(6);(b)(7) on clinical matters.
- Nurses were asked how they know when administration of as-needed medications is or is not appropriate given the lack of documentation on MARs. RNs (b)(6);(b)(7) and (b)(6);(b)(7)(C) stated communications on matters related to patient care are made at shift change.
- Officers (b)(6);(b)(7)(C) and (b)(6);(b)(7)(C) did not share the opinion voiced to them by nurses that SAMIMI was faking his symptoms. Officers (b)(6);(b)(7)(C)

(b)(6);(b)(7)(C) and (b)(6);(b)(7)(C) were assigned to medical more than once during SAMIMI's detention, and all stated his condition clearly deteriorated over time. As time progressed, they observed he was often in pain and was not tolerating food. They brought him ice and Officer (b)(6);(b)(7)(C) brought him oranges from the kitchen, peeling them for him in the hopes he would be more likely to eat them. Concerning meal trays, they said SAMIMI ate what he could, when he could. They did not share the opinion of some nurses that refusal of trays or flushing food items down the toilet was an act of defiance; rather, they believe the smell of food increased his nausea. All officers were troubled by what they perceived was a lack of concern and care for SAMIMI.

- Interviews with officers and Lieutenant (b)(6);(b)(7)(C) pointed to tension between security and health care staff. The officers reported that when they bring detainee medical issues to nurses' attention, they are typically told to tell the detainee to submit a "kite", referring to a written request. Lieutenant (b)(6);(b)(7)(C) stated he has been frustrated with medical/security relations "for a long time." He shared that he gets a call from an officer almost every night stating a detainee needs to be seen but medical will not come to the unit. Consistent with the officers' statements, the lieutenant said the response from medical staff is to tell the detainee to send a kite.

During interview of Dr. (b)(6);(b)(7)(C) he offered his own opinion on what he called animosity between officers and nurses. He said officers think nurses are not responsive when in fact, they are just over-worked and cannot respond to every complaint officers convey.

- (b)(6);(b)(7)(C)
- Disagreement over who is responsible for cleaning up bodily fluid spills feeds the tension between security and health care staff. Although GEO policy states medical staff are responsible, officers are directed to clean up body fluids unless blood is involved. During interview of Security Chief (b)(6);(b)(7)(C), he stated HSA (b)(6);(b)(7)(C) does not agree with the policy and has instructed nurses they are not to clean spills. He indicated that unless or until facility leadership decides whether the policy is to be followed as written, this particular source of tension between security and health care staff will remain.

CONCLUSIONS

Medical

Following intake screening on November 17, 2017, LPN (b)(6);(b)(7)(C) appropriately notified RN (b)(6);(b)(7)(C) that detainee SAMIMI reported he was withdrawing from high dose methadone, and RN (b)(6);(b)(7)(C) appropriately followed up by having him brought to the clinic. After speaking with SAMIMI and confirming information reported to her by the LPN, RN (b)(6);(b)(7)(C) contacted Dr. (b)(6);(b)(7)(C) for orders. In partial adherence to the CPG, he ordered housing in

medical observation, laboratory testing, vital signs every eight hours, scheduling of physician and psychologist appointments, and medications for anxiety, restlessness, sleeplessness, nausea, and pain. All medications, including clonidine, were ordered for administration as needed. Dr. (b)(6);(b)(7) opted not to order an EKG or HIV test and did not order scheduled dosing of clonidine as called for in the CPG. He also did not order monitoring of withdrawal symptoms using a standardized instrument such as the COWS.

Per Dr. (b)(6);(b)(7)(C) orders, the lab tests were completed with results essentially normal. However, vital signs were typically taken twice a day rather than every eight hours as ordered. Recorded vital signs were generally in normal limits, including blood pressure, possibly attributable to administration of clonidine at least once a day. Although ordered as needed, administration of both clonidine and Ativan was scheduled on the MAR for three set times per day. Nurses' MAR entries were inconsistent, with times of administration not recorded at all or documented at times which did not align with nursing notes. In their notes, nurses did not consistently document when medications were given based on assessment findings, or assessment findings justifying the need for medications documented on the MAR. Administration of Ativan, a controlled substance, was documented in nursing notes but not on the MAR on four occasions.

SAMIMI remained in medical housing over the course of the 16 day detention period. Although ordered by Dr. (b)(6);(b)(7) and called for in the ICE Medical Care detention standard, SAMIMI was not scheduled for an appointment with a provider. In fact, the detainee was never examined by the physician. Dr. (b)(6);(b)(7) reported having routine, casual contact with SAMIMI and receiving information on the detainee's condition and behaviors, but at no point following his initial telephone order did he direct that SAMIMI be scheduled for examination.

SAMIMI was seen by mental health professionals on three occasions. The first was for initial evaluation by psychologist Dr. (b)(6);(b)(7)(C) on November 20, 2017. Witnessing the detainee's collapse in the corridor on route to his follow up appointment on November 28, 2017, Dr. (b)(6);(b)(7) consulted Dr. (b)(6);(b)(7) and based on her observations, they collaboratively determined SAMIMI was too unstable to proceed. The next two mental health encounters were via tele-psychiatry. The first occurred November 29, 2017, 14 hours after the detainee was placed on Level 1 suicide watch. The psychiatrist ordered lowering of the suicide watch level, medication changes, and monitoring of withdrawal symptoms using COWS. No COWs was ever completed. The medication changes included discontinuation of as-needed Ativan in favor of as-needed Hydroxyzine; discontinuation of clonidine as needed in favor of three times daily; and psychiatric medication Trazodone and immodium, both as needed. Consent for Trazodone, administered only once the same day ordered, was not obtained. Documentation indicating SAMIMI was asked why he attempted suicide is not included in the encounter notes. For reasons not supported in the medical record, the attempt was called a gesture in the Mortality Review. The next and final mental health encounter, conducted via tele-psychiatry on November 30, 2017, resulted in continuation of Level 2 suicide watch and medications as ordered. The note for the encounter documented SAMIMI stated he was "stressed and depressed" and that he wanted "to

die here and not be here because of my methadone.” On December 1, 2017, Level 1 suicide watch was reinstated by Dr. (b)(6);(b)(7) based on information the detainee threw himself from his wheelchair while being taken to a follow up mental health appointment.

Although nursing notes were very limited in content and inadequately documented subjective information, they reflect a progressive deterioration in SAMIMI’s health starting November 22, 2017. Tremors, pain and weakness, nausea and vomiting, refusal to eat, inability to sit up in bed, and signs of dehydration were documented, as was the November 24 fainting incident and November 28 incident where SAMIMI collapsed en route to the mental health appointment and later attempted suicide. Thereafter, the only nursing note for November 29, 2017 includes an abnormally elevated heart rate; a nursing note for November 30, 2017 documents unexplained bleeding, apparently from the detainee’s nose. The note and security documentation indicate he screamed for the nurse throughout the early morning hours. At approximately 5:30 p.m. this date, SAMIMI had a legal call which, according to the RN and HSA, appeared to please him. HSA referenced what he observed and overheard to support his impression that SAMIMI “did a bit of acting” while in medical observation. Consistent with this comment, nursing staff suggested during interviews that they believed SAMIMI was malingering and drug seeking, and Dr. (b)(6);(b)(7) stated he engaged in behavior “to get what he wanted.”

During the early morning hours of December 1, 2017, approximately nine hours after the legal call, video shows SAMIMI in an extremely weakened condition, dropping his cup in the toilet after unsuccessfully trying to reach up to the sink for water. He appears unable to sit up and falls over more than once. The nurse who responded, RN (b)(6);(b)(7)(C) documented that SAMIMI was offered water and when asked, said he had a nightmare. His vital signs were normal. The note does not address the level of SAMIMI’s apparent weakness as shown on the video. Approximately six hours later, RN (b)(6);(b)(7)(C) declined to honor the detainee’s request for assistance moving to a wheelchair for transport to a mental health appointment. According to the RN, SAMIMI threw himself from the wheelchair while en route, sustaining a nosebleed and urinating on himself. The appointment was cancelled, and no further nursing encounters were documented this date.

Security documentation reflects SAMIMI’s condition deteriorated starting at approximately 10:30 p.m. on December 1, 2017 when he appeared to spit up blood. RN (b)(6);(b)(7)(C) responded 75 minutes later. Overnight, the detainee complained of stomach pains and was observed frequently vomiting in the toilet, and nurses were called for multiple times. He was also found to have urinated on himself. The nursing note addressing overnight events documents SAMIMI screamed for nurses, complaining of abdominal pain and inability to breathe. He was given but removed a re-breather mask, and an injection of Zofran was given for nausea per verbal order of Dr. (b)(6);(b)(7)(C).

At 10:15 a.m. on December 2, 2017, Officer (b)(6);(b)(7)(C) documented SAMIMI was eating. Twenty minutes later, at 10:35 a.m., the detainee was vomiting and screaming of stomach pain. RN

(b)(6);(b)(7)(C) was notified and over the course of the next fifteen minutes, was notified two additional times as SAMIMI continued to yell and scream. The instruction from RN (b)(6);(b)(7)(C) was that SAMIMI be taken to the mental health office for an 11:00 a.m. appointment. When the officer refused without the presence of medical staff, RN (b)(6);(b)(7)(C) responded and gave the detainee medication. Vital signs were not taken. When it became evident he could not ambulate on his own, the RN and Officers (b)(6);(b)(7)(C) and (b)(6);(b)(7)(C) moved him into a wheelchair. The video shows SAMIMI immediately stiffens, appears to shake, and is caught before sliding from the wheelchair onto the floor. He is lifted back to his mattress in the cell and shortly thereafter, vomits. RN (b)(6);(b)(7)(C) stated he decided to contact the physician to suggest alternative placement rather than calling 911 himself because the situation was not a “true emergency.” Unable to reach Dr. (b)(6);(b)(7)(C) on his cell or home phones, the RN called the HSA and received authorization to send SAMIMI to the hospital. In the meantime, Officer (b)(6);(b)(7)(C) contacted Lieutenant (b)(6);(b)(7)(C) who, upon arriving on scene, determined 911 should be called. EMS arrived within four minutes. SAMIMI stopped breathing very quickly thereafter and the paramedics started and continued CPR through his placement in the ambulance and transfer to hospital emergency room personnel.

Compliance Findings

Creative Corrections cites the following deficiencies in the ICE PBNDS 2011, revised 2016:

Medical Care, Section (V)(B), which states, “All facilities shall provide medical staff and sufficient support personnel to meet these standards.”

- Positions for key personnel, including the sole midlevel provider and Director of Nursing, were vacant for longer than six months. According to Dr. (b)(6);(b)(7)(C) and HSA (b)(6);(b)(7)(C) the midlevel provider was responsible for conducting initial health appraisals for detainees with chronic conditions. Since the position became vacant, RNs have routinely conducted these initial health appraisals. SAMIMI did not receive a health appraisal by either the physician or an RN. In addition, absent a Director of Nursing or other nurse supervisor between nursing staff and Dr. (b)(6);(b)(7)(C) clinical supervision was inadequate to assure adherence to provider orders and necessary and appropriate care.

Medical Care, Section (V)(G)(12), which states, “Each detention facility shall have and comply with written policy and procedures for the management of pharmaceuticals, to include:

12) documentation of accountability for administering or distributing medication in a timely manner, and according to licenses provider orders.”

- Prescription orders for treatment withdrawal were written for up to three times daily, as needed, for anxiety, restlessness, sleeplessness, nausea, and pain. In spite of frequent and

progressive complaints of these symptoms, the MAR and nursing notes show SAMIMI was given fewer than half of the allowed doses.

- Neither nursing notes nor the MAR consistently document times medications were administered, making it difficult, if not impossible, for nurses on subsequent shifts to know when SAMIMI was due for his next dose.

Medical Care, Section (V)(J), which states, “Where there is a clinically significant finding as a result of the initial screening, an immediate referral shall be initiated and the detainee shall receive a health assessment no later than two working days from the initial screening.”

- The identification of early opioid withdrawal symptoms did not result in referral for initial provider assessment within two working days following intake screening.

Medical Care, Section (V)(K), which states, “Detainees experiencing severe or life-threatening intoxication or withdrawal shall be transferred immediately to an emergency department for evaluation. Once evaluated, the detainee will be referred to an appropriate facility qualified to provide treatment and monitoring for withdrawal, or treated on-site if the facility is staffed with qualified personnel and equipment to provide appropriate care.”

- SAMIMI exhibited progressive symptoms of withdrawal over the detention period, becoming pronounced and life threatening during the last 48 hours. He was not transferred to the emergency room until within an hour of his death.

Medical Care, Section (V)(M), which states, “Each facility’s health care provider shall conduct a comprehensive health assessment, including a physical examination and mental health screening, on each detainee within 14 days of the detainee’s arrival unless more immediate attention is required due to an acute or identifiable chronic condition.”

- An initial physical assessment was never completed during the 15 day detention period.

Medical Care, Section (V)(N), which states, “Where a detainee has a serious medical or mental health condition or otherwise requires special or close medical care, medical staff shall complete a Medical/Psychiatric Alert form (IHSC-834) or equivalent, and file the form in the detainee’s medical record.”

- There was no alert in the medical record.

Medical Care, Section (V)(R), which states, “An initial dental screening shall be performed within 14 days of the detainee’s arrival. The initial dental screening may be performed by a dentist or a properly trained qualified health provider.”

- There is no documentation SAMIMI was scheduled for or received a dental screening examination.

Medical Care, Section (V)(T), which states, “An on-call physician, dentist, and mental health professional or designee, are available 24 hours per day.”

- RNs reported difficulty reaching the physician after hours. On the day of SAMIMI’s death, the physician did not answer or return two phone calls.

Medical Care, Section (V)(U), which states, “Distribution of medication (including over the counter) shall be performed in accordance with specific instructions and procedures established by the HSA, in consultation with the CMA. Written records of all prescribed medication given to or refused by detainees shall be maintained.”

- Phenergan given on November 25, 2017 was not documented on the MAR.
- Administration of Ativan, a controlled medication, was documented in nursing notes on November 17, 20, 21 and 27 but was not documented on the MAR.
- A refused dose of clonidine on December 1, 2017 was not addressed in the nursing notes, nor was a refusal form completed.
- The MAR did not document administration of clonidine on December 2, 2017, at 9:00 a.m.

Medical Care, Section (V)(X), which states, “The facility administration and clinical medical authority shall ensure that the Field Office Director is notified as soon as practicable of any detainee housed at the facility who is determined to have a serious physical or mental illness or to be pregnant, or have medical complications related to advanced age, but no later than 72 hours after such determination. The written notification shall become part of the detainee’s health record file.”

- The Field Office Director was not notified SAMIMI was withdrawing from methadone and that his condition was deteriorating.

Medical Care, Section (V)(AA), which states, “Prior to the administration of psychotropic medication, a separate documented informed consent, that includes a description of the medication’s side effects.”

- An informed consent specific to the anti-depressant/sedative Trazodone was not completed and signed by the detainee.

Significant Self Harm and Suicide Prevention and Intervention, Section (V)(F), which states, “All suicidal detainees placed in an isolated confinement setting will receive continuous

one-to-one monitoring, welfare checks at least every 8 hours conducted by clinical staff, and daily mental health treatment by a qualified clinician.”

- No welfare checks by clinical staff were completed during the 14 hours between placement on suicide watch and evaluation via tele-psychiatry. Thereafter, the next nursing round was 15 hours later.

In addition, the following violations of GEO policy are cited:

905-A, Medical Observation, which states, 1) Nursing personnel will complete the Medical Observation Nursing Progress Record, form 142.6, upon entry to the observation area; 2) Subsequent assessments will be documented on each shift; 3) A patient status note and vital signs will be performed and documented every two hours unless directed otherwise by the physician/designee and will be entered into a progress note; 4) Detainees admitted for 24 hour observation may, but are not required to, receive skilled nursing intervention; 5) The responsible clinician/designee will write a daily note for each detainee on medical observation for more than 24 hours.”

- Nursing assessments were not performed on each shift;
- Vitals signs were not taken every eight hours as ordered by the physician;
- Daily notes were not written by the clinician or designee.

“Time Limits: Detainees will not be housed in the medical observation area for more than 24 hours without a physician’s/designee’s order, Medical observation may be continued for three (3) consecutive 24-hour periods (up to 72 hours). Each renewal of medical observation after 24 hours must be approved through notification of the responsible physician/designee. Medical observation may not be continued beyond 72 hours. After 72 hours the detainee must be admitted as an infirmary patient in an institution with an infirmary, discharged to the general population, or transferred to a higher level of care.”

- Dr. (b)(6);(b)(7) did not renew his orders for SAMIMI’s placement in medical housing.

902, Alcohol and Drug Assessment and Treatment, which states, “Detainees at risk for progression to more severe levels of intoxication or withdrawal will be kept under constant observation in the infirmary/medical observation area by health care staff, and whenever detainee symptoms are observed, a physician will be consulted promptly. Detainees experiencing severe, life-threatening intoxication or withdrawal will be immediately transferred to an acute care facility.”

- On at least two occasions, November 30 and December 1, 2017, the night nurse failed to call the physician despite her observation of serious clinical symptoms.

Areas of Note

- DCDF holds current NCCHC accreditation; however, the medical department failed to comply with NCCHC standard J-G-07, which states: “Detoxification and withdrawal are best managed by a physician or other medical professional with appropriate training and experience. As a precaution, severe withdrawal symptoms must never be managed outside of a hospital. Deaths from acute intoxication or severe withdrawal have occurred in correctional institutions. In deciding the level of symptoms that can be managed safely at the facility, the responsible physician must take into account the level of medical supervision that is available at all times. Clinical management should also include the use of validated withdrawal assessment instruments, such as the Clinical Opiate Withdrawal Scale or the Objective Opiate Withdrawal Scale in case of opiate withdrawal, and the Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised, in the case of alcohol withdrawal.”

Nurses reported they were unfamiliar with the COWS and that they were never trained in opioid withdrawal. Through their actions, nurses demonstrated a lack of understanding of opioid withdrawal symptoms, including that drug seeking is to be expected. They also demonstrated inability to properly monitor a patient withdrawing from opioids and to recognize related life-threatening symptoms. Given the nation’s current opioid epidemic, staff preparedness is fundamental to assuring patients are provided with appropriate care.

- Related to the above, nurses did not fulfill the psychiatrist’s November 29, 2017 order to complete a COWS on a daily basis.
- Dr. (b)(6);(b)(7) based his orders on the CPG governing opioid withdrawal, but opted not to follow it in total. In so doing, he exercised provider judgment. He did not order an EKG and HIV test, ordered clonidine as needed instead of three to four times daily, and did not order nurses to ensure SAMIMI’s blood pressure was not below a set threshold before giving clonidine.
- As noted in above compliance findings, Dr. (b)(6);(b)(7) never conducted an examination of detainee SAMIMI. Although a nurse erred by not adding the detainee to the physician’s schedule originally, at no point during the detention period did Dr. (b)(6);(b)(7) follow up and direct scheduling of an appointment. His reported casual contacts with SAMIMI and his acknowledged familiarity with events as they occurred support that it was reasonable for him to do so.
- The following concerns related to administration of medications are noted:
 - Despite frequent and progressive complaints of restlessness, sleeplessness, nausea and pain, SAMIMI was given less than half the possible doses of as-needed

medications ordered by Dr. (b)(6);(b)(7) to treat these symptoms. The MAR shows only five of 42 doses were given for anxiety, 21 of 42 doses were given for restlessness/sleeplessness, 17 of 42 doses were given for pain, and only four of 42 doses were given for nausea and vomiting.

- Nursing notes did not consistently document justification for administration of as needed medications, or assessment of need.
 - Administration of medications documented in nursing notes was not recorded on MARs on five occasions.
 - Nurses sometimes refused medications until the detainee ate, rather than provide anti-nausea medication to enhance his appetite.
 - Nurses often failed to document the time of medication administration. Absent documentation of times medications were given, nurses on later shifts could not know when another dose was or was not due. The poor documentation on MARs may have contributed to SAMIMI receiving well under 50 percent of possible doses of medications as needed for anxiety, restlessness, sleeplessness, nausea and pain.
 - The MAR documents administration of two medications after SAMIMI was transported to the hospital.
- The manifestation of severe withdrawal symptoms did not result in prompt transfer to the hospital. The direction to call 911 on December 2, 2017 was given by a lieutenant while the nurse attempted to reach the physician and HSA.
 - The intake screening did not address current symptoms of withdrawal as called for on the screening form.
 - Vital signs were not obtained every eight hours as ordered by the physician.
 - Weights were not obtained to determine rate of weight loss, particularly important given SAMIMI's refusal of meals and inability to keep food down.
 - There were no medical record entries on November 19, 2017.
 - Patient safety through fall prevention was not maintained. Video showed incidents in which SAMIMI appeared to hit his head or come close to doing so on the floor or against the wall.
 - The following concerns related to medical record charting were identified:
 - Nursing notes were brief and inadequate, particularly with respect to subjective information.
 - Progress notes were not written in SOAPE format.

- Encounter times were not always noted.
 - Nursing assessments did not consistently document pain levels.
 - Nurses did not consistently document the justification for giving as-needed medications.
 - Verbal/telephone orders were incorrectly documented.
 - Complete assessments for dehydration were not documented.
- On Friday, November 24, 2017, a full injury assessment was not completed after SAMIMI fainted.
 - Nurses did not encourage SAMIMI to shower. He was described as disheveled and having a strong body odor.
 - Physician's verbal orders for medications issued November 17, 2017 were not authenticated.
 - Entries in the Constant Watch Logbook document that security staff notified nurses on multiple occasions that detainee SAMIMI required medical attention. Based on medical record entries, response was delayed.
 - Leading up to the medical emergency, Officer (b)(6);(b)(7)(C) exercised sound judgment by refusing to move SAMIMI to the mental health office without medical personnel present. Likewise, Officer (b)(6);(b)(7)(C) took appropriate action by notifying Lieutenant (b)(6);(b)(7)(C) of events surrounding the attempt to place SAMIMI in the wheelchair, and Lieutenant (b)(6);(b)(7)(C) decision to call 911 was unquestionably proper. The degree to which doubts about the legitimacy of SAMIMI's actions during withdrawal had a bearing on nurses' failure to call 911 cannot be determined.

Safety and Security

Security staff did not make all required log entries documenting whether SAMIMI accepted or refused meals and shower and recreation privileges. Most critically given his condition, officers did not make entries documenting whether he accepted the lunch and dinner meals on November 29, 2017. Log entries over the detention period reflect that SAMIMI declined all offered opportunities to shower and went to the TV room only once, and refused 17 meals. Between November 24 and the last tray offered on December 2, 2017, the detainee accepted only six meals. Although SAMIMI did not miss nine consecutive meals which would have triggered a review under the facility's hunger strike protocols, on November 17, 2017, an officer documented that the detainee declared he was on a hunger strike. According to GEO policy, this declaration should have triggered daily monitoring in accordance with GEO policy. There is no documentation any action was taken. Despite log entries and events pointing to SAMIMI's

deteriorating condition over the detention period, this case was not elevated by security supervisors or medical staff for multi-disciplinary review until November 29, 2017. On that date, SAMIMI was discussed at a routine weekly meeting per mandate to review detainees on suicide watch. The SDDO recalled it was reported the detainee was a long-time drug user, but nothing further concerning his withdrawal status and duration in medical housing was discussed.

Important events were not documented in the log, including events surrounding SAMIMI's reportedly "drinking from the toilet" and lowering of suicide watch status from Level 2 to Level 1. Also, his uniform was not confiscated as required by post orders. On multiple occasions, officers opened SAMIMI's cell door without another officer present and without documenting notification of the shift supervisor. Medical Utility Officer Post Orders require that two officers be present and notification of the shift supervisor prior to opening the cell door. Given the detainee's condition as shown in video footage, reviewers recognize officers were acting in what they believed was in the best interest of the detainee and that no security risk was evident.

Security staff demonstrated compassion and concern for detainee SAMIMI. They reported medical staff were notified of the detainee's requests and complaints; obtained food items from the kitchen; encouraged him to eat, drink and shower; provided clean linens and clothing; and cleaned his cell and his person, including vomit, urine and feces. Although current policy states a health services staff member will clean any spill of blood or other body fluids, current practice is for spills to be handled by security staff unless blood is present. Security personnel hold the policy should be maintained and followed; the HSA holds health care staff should not be required to clean body fluid spills.

In the course of the medical emergency, the officer appropriately requested that the lieutenant report to medical due to her concerns about the unfolding events. The lieutenant arrived quickly and directed that 911 be called. Without the intervention of security staff, the medical emergency would have escalated prior to arrival of EMS.

Officers made appropriate entries to the hospital log and remained with SAMIMI following his death until authorized to return to DCDF. The officers at the hospital at the time of death and all staff who responded to the medical emergency completed incident reports. However, the officer on duty during the shift preceding the medical emergency did not submit a report documenting events on his shift until an unknown date following the death. Officers involved in the medical emergency were offered supportive counseling; nurses involved in SAMIMI's care were not. All necessary video footage was retained, though none was viewed by personnel participating in two separate after action reviews. As a result, conclusions were reached during those reviews based on incomplete or inaccurate information.

Compliance Findings

Creative Corrections identified no deficiencies in the applicable ICE PBNDS 2011, 2016 revisions.

The following violations of facility policies and post orders were identified.

Medical Utility Officer Post Order, section (V)(D)(10), which states, “All necessary documentation shall be completed prior to the end of your work period and forwarded to your immediate supervisor.

- Officer (b)(6);(b)(7)(C) did not complete an incident report documenting significant events prior to the end of his shift.

Medical Utility Officer Post Order, section (V)(1)(c), Level 1 One-on-One Observation which states, “The detainee will be given appropriate suicide preventative clothing. All non-suicide preventative articles of clothing will be removed from the detainee. This will include the detainee’s undergarments.”

- When placed again on Level 1 observation/suicide watch on December 1, 2017, the detainee was allowed to retain his detention uniform.

Medical Utility Officer Post Order, section (V)(1)(g), Level 1 One-on-One Observation which states, “The Cell door will not be opened under any circumstances without two officers being present and the on duty Shift Supervisor being notified of the need to open the cell.”

- On several occasions, officers opened the cell door when detainee SAMIMI was on Level 1 suicide watch without another officer present or without any documentation a shift supervisor was notified and gave approval.

DCDF Policy 11.2.31, Permanent Logs and Reports, sections (A) and (H), which state respectively, “Logs will be maintained to reflect the activities of each post or other area on a shift-by-shift basis and to document emergency situations, unusual incidents, and other pertinent information regarding detainees and activities on the post.”; and “Make written and oral reports as necessary”.

- Officer (b)(6);(b)(7)(C) did not log in the Constant Watch Logbook when SAMIMI was moved from Level 2 to Level 1 suicide watch.
- During his shift from 11:00 p.m. on December 1 to 7:00 a.m. on December 2, 2017, Officer (b)(6);(b)(7)(C) did not document in the Constant Watch Logbook all pertinent information that occurred on the shift.

These lapses also violate the Medical Officer Utility Post Orders which require the officer to document “any unusual occurrences”.

DCDF Policy 17.1.2 Sanitation Procedures, section (I), Blood or other body fluid, which states, “Following any incident where there is spillage of blood or other body fluids the area shall be sanitized immediately by a member of the health service staff...”. “Medical staff will utilize “Clean-Up Kits” to clean up any blood and body fluids as well as decontaminate the area”.” Security staff are responsible to ensure the area is secure and that all persons entering the area are donning appropriate personal protective equipment.

- Security personnel are being required to clean up bodily fluids such as urine, feces and vomit. Medical personnel are only cleaning spills that contain blood. The Security Chief believes medical staff should clean any spills in accordance with the policy. The HSA believes that medical staff should only clean spills containing blood. The lack of adherence to the policy and the disagreement between the Security Chief and HSA has contributed to the tension between the two disciplines. The policy needs to be followed or amended.

GEO Policy 614, Hunger Strikes, which states, “Detainees declaring and/or identified as being on a Hunger Strike (missed 9 consecutive meals) will be monitored daily.”

- At 6:59 p.m. on November 27, 2017, the assigned medical officer documented in the logbook that SAMIMI informed the officer he was “on a hunger strike.” There is no further documentation in the logbook. This notification by the detainee should have triggered daily monitoring. A supervisor next reviewed the logbook at 3:20 a.m. and supervisors are required to “review and sign the log” in accordance with the Permanent Logs and Reports policy noted above. No action taken as a result of this statement is documented.

Areas of Note

- On six occasions, officers did not make entries to the Medical Housing Unit Log documenting acceptance or refusal of showers, recreation, and meals. Missed meal entries include lunch and dinner on November 29, 2017. If refused, SAMIMI did not accept seven consecutive meals.
- Most signatures of security supervisors and medical staff on the Medical Unit Housing Log forms were illegible. Ensuring staff documenting rounds are easily identifiable

ensures accountability and that the proper staff can be contacted when additional information is needed at a later date.

- While security staff routinely documented that the detainee was not eating meals, it is unclear how this information was communicated, if at all, to medical staff.
- The medical officer had a non-functioning radio when she made a round on November 28, 2017 and discovered SAMIMI with a sheet around his neck. Equipment should be regularly checked to ensure its operability in the event of an emergency.
- The GEO track system erroneously documented the date and time of the detainee's placement on suicide watch.
- The GEO Suicide Watch Log and Notes form #HS-207 lists Level 1 as "Constant Observation" while the DCDF post orders for the Medical Utility Officer refer to Level 1 as "Continual Observation". The GEO Suicide Watch Log and Notes form #HS-207 lists Level 2 as "Fifteen Minute Checks" while the DCDF post orders for the Medical Utility Officer refer to Level 2 as "Constant Observation" requiring 15 minute checks. The forms and post orders should consistently define the two levels to avoid staff confusion.

APPENDIX 1

SAMIMI VITAL SIGNS

Dr. (b)(6):(b)(7) ordered that vital signs be taken every eight hours. The below table lists vital signs documented in nursing notes and blood pressure documented on the Blood Pressure Record on November 25, 30 and December 1, 2017. Shaded areas indicate missing vital signs.

DATE	TEMPERATURE	PULSE	RESPIRATIONS	BLOOD PRESSURE	OXYGEN
11/17/2017	97.9	75	21	146/94	
11/17/2017	98.2	94	16	130/94	100
11/17/2017					
11/18/2017	97.1	75	16	104/67	95
11/18/2017	98.0	65	17	110/74	
11/18/2017					
11/19/2017					
11/19/2017					
11/19/2017					
11/20/2017				106/76	
11/20/2017		94	16	130/94	100
11/20/2017					
11/21/2017	97.6	87	16	118/76	95
11/21/2017					
11/21/2017					
11/22/2017	98.2	82	17	108/74	99
11/22/2017					
11/22/2017					
11/23/2017	98.1	82	16	107/74	97
11/23/2017	97.8	76	16	134/93	98
11/23/2017					
11/24/2017	98.2	102	18	128/83	93
11/24/2017	98.8	77	18	129/85	96
11/24/2017					
11/25/2017	97.8	76	16	134/93	98
11/25/2017		91	16	127/93	96
11/25/2017				117/88	
11/26/2017	98	111	16	107/81	99
11/26/2017	97.6	71	16	125/85	96
11/26/2017		92	16	126/78	96

11/27/2017		98	12	124/80	95
11/27/2017					
11/27/2017					
11/28/2017	98.1	107	18	124/91	95
11/28/2017					
11/28/2017					
11/29/2017	97.7	120	16	108/82	100
11/29/2017					
11/29/2107					
11/30/2017	97.6	88	16	100/70	95
11/30/2017	97.8	100	15	101/70	99
11/30/2017				100/76	
12/01/2017		84	16	101/64	96
12/01/2017		94	18		
12/01/2017				112/68	
12/02/2017	98.2	92	17	113/68	94
12/02/2017		100	17	92/68	95

APPENDIX 2
SAMIMI MEDICAL HOUSING LOG

DATE	MEALS	SHOWER	RECREATION	MEDICAL ROUND	SUPERVISOR ROUNDS
11/18/2017	3	No	No	Yes	Yes
11/19/2017	3	No	No	Yes	Yes
11/20/2017	3	No entry	No entry	Yes	Yes
11/21/2017	3	No	No	Yes	Yes
11/22/2017	3	No	No	Yes	Yes
11/23/2017	3	No	No	Yes	Yes
11/24/2017	0	No	No	Yes	Yes
11/25/2017	0	No	No	Yes	Yes
11/26/2017	1 (breakfast)	No	Yes	Yes	Yes
11/27/2017	0	No	No	No entry	Yes
11/28/2017	2 (breakfast, lunch)	No	No	No entry	1 st and 2 nd shift
11/29/2017	1 (breakfast); no entries for lunch and dinner	No entry	No entry	Yes	Yes
11/30/2017	0	No	No	Yes	1 st and 3 rd shift
12/1/2017	1 (dinner)	No	No	Yes	No entries

A22732918

SAMIMI, KAMYAR

DOB: 1/3/1953 Nation: IRAN

Arrival Date: 11/17/2017 16:00

INTAKE SCREENING

I/D/R #:	Sex: <u>M</u>	DOB:	Facility Name: Aurora ICE Processing Center
What language do you speak? <u>English</u> <u>Parsi</u>	Interpreter Name and/or #: <u>N/A</u>		

Is the I/D/R unconscious or have obvious pain, bleeding, injuries, or other symptoms suggesting need for emergency medical referral?
☒ No ☐ Yes If yes, explain:

I/D/R was identified by (source): ☐ ID Card ☐ Picture ☒ Verbally ☐ Arm band ☐ Other (Explain):

If I/D/R was transferred from another facility, did a medical transfer summary accompany the I/D/R? ☒ No ☐ Yes ☐ N/A

If I/D/R transferred from another facility, did the I/D/R arrive with medications? ☒ No ☐ Yes If yes, explain:

Medical Screening

- How do you feel today? (Explain in his/her own words): I have withdrawal symptoms
- Have you fainted recently or have you ever had a head injury with loss of consciousness? ☒ No ☐ Yes If yes, explain:
- Are you now or have you been treated by a doctor within the last 5 yrs for a medical condition, including hospitalizations? ☒ No ☐ Yes If yes, explain:
☐ Diabetes ☐ Seizure ☐ Asthma/COPD ☐ Ulcer ☐ HTN ☐ Heart condition ☐ Kidney Disease ☐ Liver Disease ☐ Other
- What surgeries have you had? Yes my hand, my back from car accident
- Do you have a history of or current communicable illness: VD, Syphilis, Hepatitis B or C, HIV/AIDS ☒ No ☐ Yes If yes, explain:
- Have you ever had a TB skin test? ☒ No ☐ Yes Results: N/A where? N/A
Have you ever had TB? ☒ No ☐ Yes If yes, year of infection: N/A
Have you ever been in contact with anyone who had TB? ☒ No ☐ Yes
Have you ever been treated for TB? ☒ No ☐ Yes If yes, when? N/A where? N/A
Last chest X-ray: (date) Results of chest X-ray:
- In the last year, have you had a persistent and productive cough for more than three weeks, had chest pain, coughed up blood, had a persistent fever, chills, night sweats, unexplained loss of appetite or weight loss, back pain, blood in your urine? ☒ No ☐ Yes If yes, explain:
- Do you take any medications on a regular basis, including over-the-counter and/or herbal medications? ☐ No ☒ Yes If yes, list the medications:
Methodone 190 mg 1 tab daily
Does the I/D/R identify as transgender? ☒ No ☐ Yes What gender does the I/D/R relate to? Male
History of transgender related health care? ☒ No ☐ Yes
- Do you have any allergies to medication, food or latex? ☒ No ☐ Yes If yes, explain:
- Are you on a special diet prescribed by a doctor? ☒ No ☐ Yes If yes, explain:
- Females Only: Date of last menstrual period: N/A Are you pregnant? ☒ No ☐ Yes If yes, have you seen an OB? ☐ No ☐ Yes
Recent abortion or delivery ☐ No ☐ Yes If yes, date: N/A Birth control ☐ No ☐ Yes ☐ N/A Method: N/A
Last Pap test date: N/A ☐ Normal ☐ Abn. ☒ N/A Current female problems: N/A
- Do you have any significant medical problems we have not discussed? ☒ No ☐ Yes If yes, explain:
- Is there any significant family medical history? ☒ No ☐ Yes If yes, explain:

Substance Use/Abuse Screening

- Have you ever smoked cigarettes/cigars? ☐ No ☒ Yes If yes, how long have you smoked? 45 years
How many cigarettes/cigars per day? 10 per day When did you last smoke? 10 hours ago
 - Do you use smokeless tobacco? ☒ No ☐ Yes If yes, how long? N/A When did you last use smokeless tobacco? N/A
 - Do you now or have you ever used alcohol or drugs? ☐ No ☒ Yes If yes, give details below (legal and illegal drugs)
- | Substance Used | Route of Use | Date of Last Use | How Often | Amount/Quantity Last Used |
|---------------------|--------------|------------------|-------------|---------------------------|
| Alcohol | N/A | Before 30 years | Occasional | 2-3 beer |
| Cocaine/Crack | Snore | Before 20 years | once a week | 1/2 gram |
| Marijuana | Smoke | 20 years ago | once a week | 1/2 gram |
| Heroin | N/A | N/A | N/A | N/A |
| Methamphetamine | N/A | N/A | N/A | N/A |
| Other: | N/A | N/A | N/A | N/A |
| Other: <u>Opium</u> | Smoke | 20 years ago | daily | 1 gram |
- Have you ever suffered withdrawal symptoms from drugs/alcohol? ☐ No ☒ Yes If yes, explain: yes
 - Have you ever been treated for drug or alcohol problems? ☐ No ☒ Yes If yes, circle all that apply and provide further explanation:
Detox ☐ Residential ☐ Outpatient ☒ methadone outpatient, Methodone

Mental Health Screening

19. Have you ever received counseling for mental health difficulties? ☒ No ☐ Yes If yes, explain:

20. Have you ever been hospitalized for mental health difficulties? ☒ No ☐ Yes If yes, explain:

21. Have you ever received medication for mental health difficulties? ☒ No ☐ Yes If yes, explain:

22. Do you have any learning disabilities? ☒ No ☐ Yes If yes, explain:

23. Were you in any special education classes? ☒ No ☐ Yes If yes, explain:

24. Do you now or have you ever heard voices that other people don't hear; seen things or people that others don't see; or felt others were trying to harm you for no logical or apparent reason? ☒ No ☐ Yes If yes, explain:

25. Have you ever tried to kill yourself? ☒ No ☐ Yes How many times? _____ If yes, when did the suicide attempts occur? N/A
Method: ☐ Gun ☐ Hanging ☐ Cutting Skin ☐ Pills ☐ Other (Explain): _____

26. Are you currently thinking about killing or harming yourself? ☒ No ☐ Yes If yes, make referral immediately and ensure safety.

27. Have you ever been a victim of physical or sexual abuse? ☒ No ☐ Yes If yes, explain:

28. Do you have a history of sexual aggression or sexual assault? ☒ No ☐ Yes If yes, explain:

29. Do you feel that you are currently in danger of being physically or sexually assaulted? ☒ No ☐ Yes If yes, explain:

30. Do you have a history of assaulting or attacking others, or have you ever been locked up for fighting while in jail or prison? ☒ No ☐ Yes

31. Do you know of someone in this facility whom you wish to attack? ☒ No ☐ Yes If yes, who is this person? N/A
If yes, inform security immediately.

32. Do you know of someone in this facility who wishes to harm you? ☒ No ☐ Yes If yes, who is this person? N/A
If yes, inform security immediately.

Pain Assessment

33. Are you currently having any pain? ☒ No ☐ Yes If yes, complete pain assessment below:

Character of Pain: <u>Sharp</u>	Location: <u>back</u>	Duration: <u>chronic</u>	Intensity: (0-10 pain scale) <u>6/10</u>
			What relieves your pain or make it worse? <u>meth</u>

Oral Screening

34. Do you have any dental problems? ☐ No ☒ Yes If yes, explain: accident, broke
Visualize the mouth, teeth and gum) Are there any dental problems noted? ☐ No ☒ Yes If yes, explain: lost front teeth

Summary Question

35. Do you have any medical, dental, or mental health issues we have not discussed? ☒ No ☐ Yes If yes, explain:

Instructions in oral hygiene and preventive oral education given? ☒ No ☐ Yes

Screener's Observation

O:

☒ I/D/R is oriented to person, place, and time ☐ I/D/R is not oriented to: _____ Person _____ Place _____ Time _____

I/D/R appears to have normal physical appearance, emotional characteristics, and no barriers to communication ☐ No ☒ Yes

I/D/R appears to present with a low level of intellectual functioning based on history and/or current presentation ☐ No ☒ Yes

Does I/D/R behavior or physical appearance suggest the risk of suicide or assault on staff or other inmates? ☐ No ☒ Yes

Check the appropriate boxes for your observations (Explain any checked boxes under comments): ☒ None of the following observed

<input type="checkbox"/> Intoxication or withdrawal from drugs/alcohol	<input type="checkbox"/> Bizarre or abnormal behavior	<input type="checkbox"/> Inability to focus/concentrate or agitation
<input type="checkbox"/> Excessive sweating (fever)	<input type="checkbox"/> Malnourished appearance	<input type="checkbox"/> Shaking/tremors
<input type="checkbox"/> Skin: Bumps/rash/lesions/infestations	<input type="checkbox"/> Skin: Cuts, bruises, signs of trauma	<input type="checkbox"/> Skin: Tattoos, needlemarks, tracks, jaundice
<input type="checkbox"/> Developmental disabilities	<input type="checkbox"/> Mobility restricted in any way	<input type="checkbox"/> Body deformity
<input type="checkbox"/> Aids (hearing aids, glasses, dentures)	<input type="checkbox"/> Physical aids (cane, crutch, brace)	<input type="checkbox"/> Other

Comments: _____

Vital Signs: T 97.9 P 75 Resp. 21 BP 146/94 Ht. 5'7" Wt. 135

If applicable, HCG Results: ☐ Positive ☒ Negative ☐ Refused If patient is diabetic, record glucose fingerstick: N/A

A: Initial Health Screening Completed: ☒ Yes ☐ No

P: Disposition: ☒ General Population ☐ Referral for immediate medical, mental health, or dental care ☐ Isolation until medically evaluated

Education: ☐ TB screening explained to I/D/R

☒ Access to medical/dental/mental healthcare, grievance process explained to I/D/R

☒ I/D/R given medical orientation and health information handouts in I/D/R language

☒ I/D/R was given written orientation materials and/or translations in I/D/Rs own language

☒ If a literacy problem exists, screener assisted the I/D/R in understanding education handouts.

☒ I/D/R verbalized understanding of any teaching or instruction and was asked if he or she had

A22732918

SAMIMI, KAMYAR

DOB: 1/3/1953 Nation: **IRAN**
Arrival Date: **11/17/2017 16:00**

Care/Intervention/Follow-Up: The following care/treatment was given during this intake screening:

Det added on BLP list, BLP 3x WK x 2 WK, refer ↑

Referrals made: ☐ Physician ☐ NP/PA ☐ Dentist ☒ Psychiatrist ☒ Mental Health ☐ Dental ☐ Chronic care ☐ Sick call

(b)(6);(b)(7)(C)

(b)(6);(b)(7)(C)

11/17/2017

Date/Time

Date/Time

HS-168

AUTOPSY REPORT

NAME: KAMYAR SAMIMI

ME#: A17-03073

DATE AND TIME PRONOUNCED DEAD: December 2, 2017 / 1202 Hours

DATE AND TIME OF AUTOPSY: December 6, 2017 / 1000 Hours

AGE: 64

RACE: White

GENDER: Male

CIRCUMSTANCES OF DEATH

This 64-year-old male was transported emergently to University of Colorado Hospital on December 2, 2017. He was reportedly in the custody of ICE officers at the immigration detention center in Aurora at the time of his medical incident. He had been in the facility for two weeks prior to the incident and was under a direct supervision suicide watch when he was observed to be "spitting up blood". Apparently he had been suffering from gastrointestinal bleeding in the past. His social history included opium addiction at the age of six and addiction to methadone since 1990. He had been "clean" for two weeks in the ICE facility and was being watched for withdrawal, dehydration, nausea and vomiting.

IDENTIFICATION

The decedent was identified by ICE officers. This was confirmed by fingerprints.

CIRCUMSTANCES OF POSTMORTEM EXAMINATION

The autopsy was authorized by the Coroner of Adams County, Colorado. Prosecuting was Dr. Stephen J. Cina and assisting were autopsy technicians Simpson, Morales and Hermosillo. The autopsy was performed at the Adams County Coroner's Office.

CLOTHING AND PERSONAL EFFECTS

The decedent was clad in white socks and cutaway white boxer shorts.

EXTERNAL EXAMINATION

The body was that of a thin, White male. An appropriate identification tag was on the left great toe and hospital identification tags were on the left ankle and left great toe. The body weighed 141 pounds, was 68 1/2-inches in height and appeared compatible with the reported age of 64 years.

The body was cool. Full rigor mortis was present to an equal degree in all extremities. Mild, fixed, purple lividity was distributed over the posterior surfaces of the body, except in areas exposed to pressure.

The scalp hair was receding, black with gray and 2 1/2-inches in length. Facial hair consisted of a black with gray beard and mustache. The irides were brown, the corneae were clear, the sclerae were white, and the conjunctivae were pink/tan and free of petechiae. Bloody black fluid flowed from the mouth and nose. The earlobes were not pierced. There were moderate transverse creases of the lower pinnae. The nasal skeleton was palpably intact. The lips were without evidence of injury. The lower teeth were in poor condition and the upper jaw was edentulous.

Examination of the neck revealed no evidence of injury. Perimortem injuries to the chest will be described below. The abdomen was flat and there was a possible 1-inch scar at the right anterior costal margin.

The extremities showed no gross bony deformities or pitting edema. There was a 3/4-inch scar on the right second finger and a 3/16-inch scabbed abrasion at the tip of the left second finger. The fingernails were intact. Tattoos were not noted. Needle tracks were not observed.

The external genitalia were those of a circumcised adult male. The posterior torso was essentially without note. The anus was atraumatic.

EVIDENCE OF THERAPY

Evidence of medical intervention consisted of bilateral tibial intraosseous lines; an endotracheal tube; two defibrillator pads on the chest; intravenous catheters in the right antecubital

fossa and dorsal left hand; and venipuncture sites covered by dressings on the left forearm and in the left antecubital fossa.

EVIDENCE OF INJURY

A 1/4-inch abrasion was on the right side of the bridge of the nose. A 5/8-inch abrasion was on the lateral right zygomatic region.

There were vaguely rectangular yellow abrasions overlying the sternum. Right ribs 3 - 7 and left ribs 2 - 6 were fractured anterolaterally. There was minimal associated internal bleeding.

INTERNAL EXAMINATION

Body Cavities:

The body was opened by the usual thoracoabdominal incision and the chest plate was removed. No adhesions or abnormal collections of fluid were present in any of the body cavities. All body organs were present in the normal anatomical positions. The subcutaneous fat layer of the abdominal wall was 1.2 cm thick.

Head: (Central Nervous System)

The scalp was reflected. The calvarium of the skull was removed. The dura mater and falx cerebri were intact. There was no subdural or epidural hemorrhage. The leptomeninges were thin and delicate. The cerebral hemispheres were symmetrical. The structures at the base of the brain, including the cranial nerves and blood vessels, were intact. Coronal sections through the cerebral hemispheres revealed no focal lesions. Transverse sections through the brainstem and cerebellum were unremarkable. The brain weighed 1,450 grams. The spinal cord was not examined.

Neck:

Examination of the soft tissues of the neck, including the strap muscles and large vessels, revealed no abnormalities. The hyoid bone and larynx were intact.

Cardiovascular System:

The pericardial surfaces were smooth, glistening, and unremarkable; the pericardial sac was free of significant fluid or adhesions. The coronary arteries arose normally, followed the usual distribution, and were widely patent with no evidence of significant atherosclerosis or thrombosis. The cardiac valves were unremarkable. The chambers and valves exhibited the usual size-position relationships.

The myocardium was red/brown and firm with no focal lesions; the atrial and ventricular septa were intact. The aorta and its major branches arose normally, followed the usual course, and were widely patent. The vena cavae and their major tributaries were returned to the heart in the usual distribution and were free of thrombi. The heart weighed 300 grams.

Respiratory System:

The upper airway was clear of debris and foreign material; the mucosal surfaces were smooth, yellow/tan and unremarkable. The pleural surfaces were smooth and glistening with no focal lesions. The pulmonary parenchyma was purple/tan with diffuse emphysematous changes and bullae at the apices. The parenchyma exuded a mild amount of foamy fluid upon sectioning. There was marked anthracosis. No mass lesions were noted. The pulmonary arteries were normally developed, patent, and without thrombus or embolus. The right lung weighed 480 grams; the left lung weighed 450 grams.

Liver and Biliary System:

The hepatic capsule was smooth, glistening and intact covering uniformly brown parenchyma. No mass lesions were noted. The gallbladder contained 4 mL of viscous, green/brown bile; the mucosa was velvety and unremarkable. The extrahepatic biliary tree was patent, without evidence of calculi. The liver weighed 1,500 grams.

Alimentary System:

The tongue exhibited no evidence of recent injury. The esophagus was lined by gray/white, smooth mucosa. The gastric mucosa was slightly autolyzed and the lumen contained 10 mL of bloody fluid. The small and large bowels were unremarkable.

The ilium contained approximately 100 mL of partially digested blood and firm, black stool resided within the colon. No specific site of bleeding could be identified. The pancreas had a normal gray/white, lobulated appearance and the ducts were clear. The appendix was present.

Genitourinary System:

The renal capsules were smooth and thin, semitransparent, and stripped with ease from the underlying smooth, red/brown cortical surfaces. The cortices were sharply delineated from the medullary pyramids which were purple/tan and unremarkable. The calyces, pelves, and ureters were without note. The urinary bladder was empty; the mucosa was gray/tan and wrinkled. The right kidney weighed 110 grams; the left kidney weighed 130 grams. The prostate gland was unremarkable.

Reticuloendothelial System:

The spleen had a smooth, intact capsule covering red/purple, moderately firm parenchyma; the lymphoid follicles were unremarkable. The regional lymph nodes appeared normal. The spleen weighed 120 grams.

Endocrine System:

The thyroid and adrenal glands were unremarkable.

Musculoskeletal System:

Muscle development was normal. There was moderate degenerative joint disease of the thoracolumbar vertebral column. No nontraumatic bone or joint abnormalities were noted.

SPECIMENS/EVIDENCE OBTAINED

Samples of peripheral blood, heart blood, cavity blood, gastric contents, and vitreous fluid were obtained for toxicology.

A DNA card was retained for the file.

Samples of the major organs were submitted for stock in formalin.

Two cassettes were submitted for histologic analysis.

MICROSCOPIC DESCRIPTION

A - Left lung: disrupted septae; atelectasis; anthracosis; edema; bacteria without inflammation; interstitial chronic inflammation

Liver: moderate steatosis

Left ventricle: unremarkable

B - Right lung: disrupted septae; atelectasis; anthracosis; edema; bacteria and intrabronchial gastric contents without inflammation; interstitial chronic inflammation

PATHOLOGIC DIAGNOSES

- I. Chronic obstructive pulmonary disease (emphysema) with marked anthracosis and terminal aspiration
- II. Lower gastrointestinal hemorrhage
- III. Thoracolumbar degenerative joint disease
- IV. CPR-related injuries
- V. Minor abrasions of face
- VI. Moderate hepatic steatosis
- VII. Toxicology (NMS Labs 17380380, peripheral blood): Negative
- VIII. Vitreous humor, chemistry studies:
 - A. elevated glucose (183 mg/dL)
 - B. Mild renal dysfunction
 1. Urea nitrogen = mg/dL
 2. Creatinine = 1.9 mg/dL
 - C. No evidence of dehydration

OPINION

This 64-year-old, White male, Kamyar Samimi, died of undetermined causes. Chronic obstructive pulmonary disease (emphysema) and gastrointestinal bleeding likely contributed to death. Methadone withdrawal cannot be ruled out as the cause of death, however, deaths due to methadone withdrawal are rare. There were no injuries to explain death nor was there evidence of dehydration.



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January 30, 2018

Date

Dictated: 12/6/2017

Received for transcription: 12/6/2017

Transcribed: 12/6/2017

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